

CERTIFICATE OF INSURANCE

A complete explanation of Your plan

PPO (Plan 3H5)

Important benefit information – please read



Health Net®
LIFE INSURANCE COMPANY

PPO847LRG(07/10)

Dear Health Net Covered Person:

This is Your new Health Net PPO Certificate of Insurance.

This document is the most up-to-date version. To avoid confusion, please discard any versions You may have previously received.

Thank You for choosing Health Net.

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INTRODUCTION TO HEALTH NET PREFERRED PROVIDER ORGANIZATION (PPO)

Plan 3H5

HEALTH NET PPO CERTIFICATE OF INSURANCE

ISSUED IN CONNECTION WITH THE HEALTH NET PPO GROUP INSURANCE POLICY

UNDERWRITTEN BY

HEALTH NET LIFE INSURANCE COMPANY

Los Angeles, California

HEALTH NET LIFE INSURANCE COMPANY (herein called HNL) agrees to provide benefits as described in this *Certificate* to You and Your eligible Dependents, subject to the terms and conditions of the Health Net PPO Insurance Policy (the Policy) which is incorporated herein and issued to the Group.

PLEASE READ THE FOLLOWING INFORMATION TO KNOW FROM WHOM OR WHICH GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

Preferred Providers are providers who have agreed to participate in HNL's Preferred Provider Organization program (PPO), which is called Health Net PPO. They have agreed to provide You Covered Services and Supplies as explained in this *Certificate* and accept a special contracted rate, called the Contracted Rate, as payment in full. Your share of costs is based on this contracted rate. Preferred Providers are listed on the HNL website at www.healthnet.com, or You can contact the Member Services Department at the telephone number on Your HNL ID Card to obtain a copy of the Preferred Provider Directory.

Out-of-Network Providers have not agreed to participate in the Health Net PPO program. You may choose to obtain Covered Services and Supplies from an Out-of-Network Provider. **WHEN YOU USE AN OUT-OF-NETWORK PROVIDER, BENEFITS ARE SUBSTANTIALLY REDUCED AND YOU WILL INCUR A SIGNIFICANTLY HIGHER OUT-OF-POCKET EXPENSE.** Your out-of-pocket expense is greater because: (i) You are responsible for a higher percentage cost of the benefits in comparison to the cost of benefits when services are provided by Preferred Providers; (ii) HNL's benefit for Out-of-Network Providers is based on the Maximum Allowable Amount; and (iii) You are financially responsible for any amounts these providers charge in excess of this amount. Please refer to the definition of Maximum Allowable Amount in the "Definitions" section for details.

To maximize the benefits received under this Health Net PPO insurance plan, You must use Preferred Providers. When contacting a provider, please identify yourself as a person covered under Health Net PPO.

HNL applies certain payment policies and rules to determine appropriate reimbursement that may affect Your responsibility (including, but not limited to, rules affecting reductions in reimbursement for charges for multiple procedures, services of an assistant surgeon, unbundled or duplicate items, and services covered by a global charge for the primary procedure). See the "Authorized Hospital and Skilled Nursing Facility Services" portion of the "Schedule of Benefits" section and the "Professional Services" portion of the "Plan Benefits" section for additional details. Additional information about HNL's reimbursement policies is available on the HNL website at www.healthnet.com or by contacting HNL's Member Services at the telephone number listed on Your Health Net PPO Identification Card.

Some Hospitals and other providers do not provide one or more of the following services that may be covered under this *Certificate* and that You might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; Infertility treatments; or abortion. In order to determine from whom the above health care services may be available, HNL suggests You obtain this information prior to enrollment by calling prospective Physicians, Hospitals or clinics which contract with HNL or any other provider of choice. You may also obtain this information by calling HNL's Member Services at 1-800-676-6976.

THE CONTINUED PARTICIPATION OF ANY ONE PHYSICIAN, HOSPITAL OR OTHER PROVIDER CANNOT BE GUARANTEED.

THE FACT THAT A PHYSICIAN OR OTHER PROVIDER MAY PERFORM, PRESCRIBE, ORDER, RECOMMEND OR APPROVE A SERVICE, SUPPLY OR HOSPITALIZATION DOES NOT, IN ITSELF, MAKE IT MEDICALLY NECESSARY, OR MAKE IT A COVERED SERVICE.

THE TERMS "YOU" OR "YOUR," WHEN THEY APPEAR IN THIS CERTIFICATE, REFER TO THE PRINCIPAL COVERED PERSON (THE ENROLLED EMPLOYEE). THE TERMS "WE," "OUR" OR "US," WHEN THEY APPEAR IN THIS CERTIFICATE, REFER TO HNL. PLEASE REFER TO "COVERED PERSON" AND "HNL" IN THE "DEFINITIONS" SECTION FOR MORE INFORMATION.

If You Are Enrolled In An Employer Plan That Is Subject To ERISA, 29 U.S.C. 1001 et seq., a federal law regulating some employer plans:

IN ADDITION TO THE RIGHTS SET FORTH IN THIS CERTIFICATE, YOU MAY HAVE RIGHTS UNDER APPLICABLE STATE LAW OR REGULATIONS AND/OR UNDER THE FEDERAL ERISA STATUTE.

If You Are Enrolled In A Plan That Is Not Subject To ERISA:

IN ADDITION TO THE RIGHTS SET FORTH IN THIS CERTIFICATE, YOU MAY HAVE RIGHTS UNDER APPLICABLE STATE OR FEDERAL LAWS OR REGULATIONS.

Contact your Employer to determine if You are enrolled in a Plan that is subject to ERISA.

Important Notice To California Certificate Holders

In the event that You need to contact someone about Your insurance coverage for any reason, please contact:

**Health Net Life Insurance Company
P.O. Box 10348
Van Nuys, CA 91049
1-800-676-6976**

If You have been unable to resolve a problem concerning Your insurance coverage, after discussions with Health Net Life Insurance Company, or its agent or other representative, You may contact:

**California Department of Insurance, Consumer Services Division
300 South Spring Street
South Tower
Los Angeles, CA 90013
1-800-927-HELP**

SCHEDULE OF BENEFITS

Health Net PPO Plan 3H5

The following is only a brief summary of the benefits covered under this *Certificate*. Please read the entire *Certificate* for complete information about the benefits, conditions, limitations and exclusions of this Health Net PPO insurance plan.

Medical Benefits

Certification of Covered Expenses is required in some instances or benefits may be reduced. Please see the "Certification Requirement" portion of the "Plan Benefits" section of this *Certificate* for a list of services and supplies which require Certification.

You will always be responsible for all expenses incurred for services or supplies that are not covered or that exceed the benefit maximums or other limitations of this plan.

Calendar Year Deductibles

Unless otherwise noted, the following Deductibles apply to Covered Expenses for Covered Services and Supplies provided by both Preferred Providers and Out-of-Network Providers:

Combined Calendar Year Deductible (for Preferred Provider services and Out-of-Network Providers, per Covered Person)	\$250
Combined Family Calendar Year Deductible, (for Preferred Providers and Out-of-Network Providers), per Family	\$750

Additional Deductibles

Out-of-Network inpatient Deductible (applies to each admission to an Out-of-Network Hospital; Deductible continues to apply after the Out-of-Pocket Maximum has been satisfied)	\$250
Out-of-Network inpatient Deductible (applies to each admission to an Out-of-Network Skilled Nursing Facility; Deductible continues to apply after the Out-of-Pocket Maximum has been satisfied)	\$250
Out-of-Network outpatient services, per surgery Deductible (applies for each surgical session performed at an Out-of-Network Hospital or Ambulatory Surgical Center; Deductible continues to apply after the Out-of-Pocket Maximum has been satisfied)	\$250
Emergency room Deductible	\$50
Urgent care center Deductible	\$10
Noncertified inpatient services Deductible (for each noncertified service inpatient admission).....	\$250
Noncertified outpatient services Deductible (per visit)	\$250

Note: Any amount applied toward the Calendar Year Deductible for Covered Services and Supplies received from a Preferred Provider will apply toward the Calendar Year Deductible for Out-of-Network Providers. In addition, any amount applied toward the Calendar Year Deductible for Covered Services and Supplies received from an Out-of-Network Provider will apply toward the Calendar Year Deductible for Preferred Providers.

Exceptions to the Deductibles:

- The emergency room or urgent care Deductible will not apply if the Covered Person is admitted to a Hospital directly from an emergency room or urgent care center.
- The Deductibles for noncertified inpatient and outpatient services will apply to services for which Certification was required but not obtained. Please see the "Certification Requirement" portion of the "Plan Benefits" section for a list of services that require Certification.

Out-of-Pocket Maximum

After an individual Covered Person has paid Deductibles, Copayments and Coinsurance equal to the Out-of-Pocket Maximum shown below, such Covered Person will have satisfied the Out-of-Pocket requirement and will not be required to pay further Copayments or Coinsurance for Covered Expenses incurred during the remainder of the Calendar Year, except as otherwise states. For most services, we will pay 100% of Covered Expenses for any additional services and supplies. The Covered Person will continue to be responsible for any charges billed in excess of Covered Expenses (Maximum Allowable Amounts) for the services of Out-of-Network Providers and will not be reimbursed for any amounts in excess of Maximum Allowable Amounts.

For services or supplies provided by a Preferred Provider\$1,500
 For services or supplies provided by an Out-of-Network Provider.....\$2,000

Note: Any Copayments or Coinsurance paid for the services of a Preferred Provider which are Covered Expenses will apply toward the Out-of-Pocket Maximum for Out-of-Network Providers. In addition, Coinsurance paid for the services of an Out-of-Network Provider will apply toward the Out-of-Pocket Maximum for Preferred Providers.

In addition, if enrolled Covered Persons of the same family have paid Copayments and Coinsurance equal to the amounts shown below, the Out-of-Pocket Maximum will be considered to have been met for the entire family. No Copayment or Coinsurance for Covered Expenses shall be required from any enrolled Covered Person in that family for the remainder of that Calendar Year.

For services or supplies provided by a Preferred Provider\$3,000
 For services or supplies provided by an Out-of-Network Provider.....\$3,000

Note: Any Copayments or Coinsurance paid for the services of a Preferred Provider which are Covered Expenses will apply toward the Out-of-Pocket Maximum for Out-of-Network Providers. In addition, Coinsurance paid for the services of an Out-of-Network Provider will apply toward the Out-of-Pocket Maximum for Preferred Providers.

Exceptions to the Out-of-Pocket Maximum: Only Covered Expenses will be applied to the Out-of-Pocket Maximum. However, the following expenses will not be counted, nor will these expenses be paid at 100% after the Out-of-Pocket Maximum is reached:

- Covered Expenses used by the Covered Person to meet the Calendar Year Deductible;
- Covered Expenses for which the Coinsurance is 50%;
- Penalties paid for services for which Certification was required but not received; and
- Expenses paid by the Covered Person for outpatient Prescription Drug benefits.
 - Covered Expenses for visits to a Physician, Physician assistant or nurse practitioner (through a Preferred Provider)
 - Covered Expenses for preventive care for a child or adult (through a Preferred Provider)
 - Covered Expenses for specialist consultations (through a Preferred Provider)
 - Covered Expenses for immunizations (except foreign travel/occupational (through a Preferred Provider)
 - Covered Expenses for sterilization (male and female)

Lifetime Medical Benefit Maximums

For Hospice Care (combined Preferred Provider and Out of Network Provider)\$10,000

For all medical benefits paid on behalf of each Covered Person during that Covered Person's lifetime (combined Preferred Provider and Out of Network Provider)\$5,000,000

Note: All calculations of benefit maximums (including the Lifetime Medical Benefit Maximum) for each Covered Person are based on the total aggregate amount of benefits paid under this plan and all other Health Net or HNL plans sponsored by the same employer.

Copayments and Coinsurance

You may be required to pay out-of-pocket charges for specific services and supplies after all appropriate Deductibles have been satisfied. These charges are known as Copayments and Coinsurance.

Copayments: Copayments are fixed dollar amount charges, shown below, for which You are responsible. We will pay 100% of Covered Expenses for the services listed below after the Copayment is made. The Calendar Year Deductible does not apply. Services to which no Copayment or Coinsurance amount applies (\$0) are subject to the Calendar-Year Deductible. You will be responsible for paying Copayments until the amount paid during a Calendar Year is equal to the Out-of-Pocket Maximum shown above.

Coinsurance: Coinsurance is the percentage, shown below, of Covered Expenses (as defined) for which You are responsible. After Your Deductible(s) have been satisfied, You will be responsible for paying Coinsurance until the amount paid during a Calendar Year is equal to the Out-of-Pocket Maximum.

Notes:

- Any Copayments or Coinsurance paid for the services of a Preferred Provider will apply toward the Out-of-Pocket Maximum for Out-of-Network Providers. In addition, Coinsurance paid for the services of an Out-of-Network Provider will apply toward the Out-of-Pocket Maximum for Preferred Providers.
- You will also be required to pay any charges billed by an Out-of-Network Provider that exceed Covered Expenses (Maximum Allowable Amount). You will not be reimbursed for any amount in excess of Covered Expenses (Maximum Allowable Amount). Any Copayment or Coinsurance paid for the services of a Preferred Provider will apply toward the out-of-pocket Covered Expenses (as defined).
- **UNLESS OTHERWISE NOTED, ALL BENEFIT MAXIMUMS WILL BE COMBINED FOR COVERED SERVICES AND SUPPLIES PROVIDED BY PREFERRED PROVIDERS AND OUT-OF-NETWORK PROVIDERS.**

Services in an Emergency Room or Urgent Care Center

	Preferred Providers	Out-of-Network
Emergency room care (facility and professional services).....	20%.....	20%
Emergency room deductible	\$50	\$50
Urgent care (facility and professional services).....	20%.....	20%
Urgent care deductible	\$10	\$10

Note:

- For all services which meet the criteria for Emergency Care, the Coinsurance will be the percentage shown for Preferred Providers, even if the services were provided by an Out-of-Network Provider.
- The emergency room or urgent care center Deductible will not apply if the Covered Person is admitted to a Hospital directly from an emergency room or urgent care center. See “Authorized Hospital and Skilled Nursing Facility Services” below for applicable Coinsurance.

Authorized Hospital and Skilled Nursing Facility Services

	Preferred Providers	Out-of-Network
Unlimited days of care in a semi-private room or Special Care Unit including ancillary (additional) services.....	20%	30%
<i>Deductible per admission</i>	<i>None</i>	\$250
Confinement in a Skilled Nursing Facility	20%	30%
<i>Maximum days per Calendar Year*</i>	100	100
<i>Deductible per admission</i>	<i>None</i>	\$250
Outpatient surgery (Hospital or Outpatient Surgical Center charges only)	20%	30%
<i>Maximum amount allowable by HNL per surgical session</i>	<i>No Maximum</i>	\$350
<i>Deductible per admission</i>	<i>None</i>	\$250
Outpatient services (other than surgery)	20%	30%
Routine nursery care for newborns	20%	30%
<i>Deductible per admission</i>	<i>None</i>	\$250

Notes:

- Other professional services performed in the outpatient department of a Hospital, Outpatient Surgical Center or other licensed outpatient facility such as a visit to a Physician (office visit), laboratory and x-ray services, physical therapy, etc., may require a Copayment or Coinsurance when these services are performed.
 - Diagnostic endoscopic procedures, such as diagnostic colonoscopy, performed in an outpatient facility require the Copayment or Coinsurance applicable for outpatient facility services. If, during the course of a diagnostic endoscopic procedure performed in a Hospital or Outpatient Surgical Center, a therapeutic (surgical) procedure is performed, then the Copayment or Coinsurance applicable for outpatient surgery will be required instead of the Copayment or Coinsurance for outpatient facility services.
 - The Preferred Provider Coinsurance will apply if the Covered Person is admitted to a Hospital directly from an emergency room or urgent care center. The Covered Person will remain responsible for amounts billed in excess of Covered Expenses (Maximum Allowable Amounts) for the inpatient stay by an Out-of-Network Provider. You will not be reimbursed for any amounts in excess of Maximum Allowable Amounts billed by an Out-of-Network Provider.
 - Look under the headings for the various services such as office visits, neuromuscular rehabilitation and other services to determine any additional Copayments or Coinsurances that may apply.
- * The Maximum number of days for Confinement in a Skilled Nursing Home are combined for Preferred Provider and Out of Network Provider.

Mental Disorders and Chemical Dependency Benefits

Covered services provided for the treatment of Mental Disorders and Chemical Dependency are subject to the same Deductible(s) and Copayments as required for the services when provided for a medical condition.

Severe Mental Illness or Serious Emotional Disturbances of a Child

	Preferred Providers	Out-of-Network
Outpatient consultation (psychological evaluation or therapeutic session in an office setting) *		
Visit 1-3	\$0	30%
Visit 4 and thereafter	20%	30%
Intensive outpatient care or partial hospitalization/day treatment*		
Visit 1-3	\$0	30%
Visit 4 and thereafter	20%	30%

Physician visit to Hospital, Behavioral Health Facility or Residential Treatment Center	20%	30%
Inpatient services	20%	30%

*Calendar Year Deductible waived for Preferred Provider

Other Mental Disorders **Preferred Providers** **Out-of-Network**

Outpatient consultation (psychological evaluation or therapeutic session in an office setting)*		
Visit 1-3	\$0	30%
Visit 4 and thereafter	20%	30%
Intensive outpatient care or partial hospitalization/day treatment*		
Visit 1-3	\$0	30%
Visit 4 and thereafter	20%	30%
Physician visit to Hospital, Behavioral Health Facility or Residential Treatment Center	20%	30%
Inpatient Services	20%	30%

*Calendar Year Deductible waived for Preferred Provider

Chemical Dependency **Preferred Providers** **Out-of-Network**

Outpatient consultation (psychological evaluation or therapeutic session in an office setting) for Chemical Dependency*		
Visit 1-3	\$0	30%
Visit 4 and thereafter	20%	30%
Intensive outpatient care or partial hospitalization/day treatment*		
Visit 1-3	\$0	30%
Visit 4 and thereafter	20%	30%
Inpatient Services	20%	30%
Detoxification (acute care for Chemical Dependency)	20%	30%

*Calendar Year Deductible waived for Preferred Provider

Office Visits

Preferred Providers **Out-of-Network**

Visit to a Physician's office*	20%	30%
Preventive care services for children, including vision and hearing examinations and immunizations (through age 16)*	20%	30%
Maximum amount payable by HNL per visit	No Maximum	\$20
Preventive care services for adults (age 17 and older)*	20%	30%
Annual routine physical examination	Not Covered	Not Covered
Physician visit to Covered Person's home*	20%	30%
Vision examinations (age 17 and older)*	20%	Not Covered
Hearing examinations (age 17 and older)*	20%	30%

Note:

Preventive care services for adults include mammograms, cervical cancer screening tests, pelvic exams, breast exams, digital rectal exams, fecal occult blood tests and screening and diagnosis of prostate cancer. Preventive care services for adults and for children include annual preventive physical examinations. Additional services for colorectal cancer, including but not limited to colonoscopy, may be covered under Hospital Services. Refer to the “Plan Benefits” section for additional details.

*Calendar Year Deductible waived for Preferred Provider

Allergy and Injection Services

	Preferred Providers	Out-of-Network
Allergy testing*	20%	30%
Allergy serum*	20%	30%
Allergy injection services (serum not included) **	\$15	\$15
All other injections**	\$15	\$15
Self-injectable drugs**	\$15	\$15
Other immunizations (except for foreign travel/occupational services)(age 17 and older)*	20%	30%

Note:

Certain injectable drugs which are considered self-administered are covered on the Specialty Drug tier under the pharmacy benefit. Specialty Drugs are not covered under the medical benefits even if they are administered in a Physician’s office. If You need to have the provider administer the Specialty Drug, You will need to obtain the Specialty Drug through the Specialty Pharmacy Vendor and bring it with You to the provider office. Alternatively, You can coordinate delivery of the Specialty Drug directly to the provider office through the Specialty Pharmacy Vendor.

*Calendar Year Deductible waived for Preferred Provider

**Calendar Year Deductible waived for Preferred Provider and Out of Network

Care for Conditions of Pregnancy

	Preferred Providers	Out-of-Network
Normal delivery, cesarean section, prenatal and postnatal care	20%	30%
Complications of pregnancy, including Medically Necessary terminations of pregnancy	20%	30%
Elective terminations of pregnancy.....	20%	30%
Genetic testing of fetus	20%	30%
Circumcision of newborn (birth through 30 days) *	20%	30%

*Circumcisions for Covered Persons aged 31 days and older are covered when Medically Necessary under “Outpatient Surgery.” Refer to the “Authorized Hospital and Skilled Nursing Facility Services” section for applicable Copayments and Coinsurance.

Family Planning

	Preferred Providers	Out-of-Network
Infertility services	Not Covered	Not Covered
Sterilization of males.....	30%	50%
Sterilization of females.....	30%	50%
Intrauterine device (IUD)	20%	30%

Note

The above Copayments apply to professional services only. Services that are rendered in a Hospital are also subject to the Hospital services Copayment. Look under the “Authorized Hospital and Skilled Nursing Facility Services” heading to determine any additional Copayments that may apply.

Medical Supplies

	Preferred Providers	Out-of-Network
Durable Medical Equipment	20%	30%
<i>Calendar Year maximum payable by HNL (Combined for Preferred Provider and Out-of-Network Provider).....</i>	<i>\$5,000</i>	<i>\$5,000</i>
Orthotics (such as bracing, supports and casts)	20%	30%
Corrective footwear.....	20%	30%
Diabetic equipment.....	20%	30%
Diabetic footwear	20%	30%
Prostheses.....	20%	30%
Hearing aids.....	Not Covered	Not Covered
Blood or Blood Products** (except for drugs used to treat hemophilia, including blood factors)*	20%	30%

Note:

- Diabetic equipment and orthotics which are covered under the medical benefit include blood glucose monitors, insulin pumps and corrective footwear.
- * Drugs used to treat hemophilia, including blood factors, are covered on the Specialty Drug tier under the pharmacy benefit. Specialty Drugs are not covered under the medical benefit even if they are administered in a Physician’s office. If You need to have the provider administer the Specialty Drug, You will need to obtain the Specialty Drug through the Specialty Pharmacy Vendor and bring it with You to the provider’s office. Alternatively, You may be able to coordinate delivery of the Specialty Drug directly to the provider’s office through the Specialty Pharmacy Vendor.
- **Calendar Year Deductible waived for Preferred Provider

Home Health Care Services

	Preferred Providers	Out-of-Network
Home Health Care Services	20%	30%
<i>Number of visits covered during a Calendar Year (Combined for Preferred Provider and Out-of-Network Provider)</i>	<i>100</i>	<i>100</i>

Hospice Care

	Preferred Providers	Out-of-Network
Hospice Care	20%	30%
<i>Lifetime Maximum (Combined for Preferred Provider and Out of Network Provider)</i>	<i>\$10,000</i>	<i>\$10,000</i>

Acupuncture and Chiropractic Services

	Preferred Providers	Out-of-Network
Acupuncture.....	20%	30%

Maximum amount payable by HNL per visit	\$25	\$25
Number of visits covered during a Calendar Year (Combined for Preferred Provider and Out of Network Provider)	12	12
Chiropractic services	20%	30%
Number of visits covered during a Calendar Year (Combined for Preferred Provider and Out of Network Provider)	30	30
Maximum payable by HNL per Calendar Year	No maximum	\$25

Ambulance

	Preferred Providers	Out-of-Network
Air Ambulance	20%	30%
Ground Ambulance	20%	30%

Other Professional Services

	Preferred Providers	Out-of-Network
Physician visit to Hospital or Skilled Nursing Facility	20%	30%
Surgery	20%	30%
Administration of anesthetics	20%	30%
Diagnostic imaging (including x-ray) and laboratory procedures	20%	30%
Chemotherapy	20%	30%
Radiation therapy	20%	30%
Nuclear medicine	20%	30%
Organ, stem cell or tissue transplant (not Experimental or Investigational)**	20%	Not Covered
Transplant travel expenses***	\$0	Not Covered
Renal dialysis	20%	30%
Physical therapy, occupational therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy**	20%	30%
Maximum visits per Calendar Year (Combined for Preferred Provider and Out of Network Provider)	30	30
Maximum amount payable by HNL per visit	No Maximum	\$25
Speech therapy**	20%	30%
Maximum amount payable by HNL	No Maximum	\$30
Maximum visits per Calendar Year (Combined for Preferred Provider and Out of Network Provider)	24	24
Medical social services	20%	30%
Diabetes education	20%	30%
Outpatient infusion therapy	20%	30%
Maximum amount allowable by HNL per day	No Maximum	\$600

Note:

- Benefits for up to 12 additional visits for physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy may be covered if precertified as Medically Necessary for rehabilitation services following neurological and orthopedic surgery, cerebral/cardiovascular accident, third degree burns, head trauma and spinal cord injury. All visit maximums will be combined for Covered Services and Supplies provided by Preferred Providers and Out-of-Network Providers. Coverage for physical, occupational and speech rehabilitation therapy services is subject to certain limitations as described in the "General Limitations and Exclusions" section.

*Transplant travel expenses (benefit limitations):

For transplant recipient and one companion per transplant episode (limited to 6 trips per episode)

1. Transportation to transplant center: \$250 per trip for each person (round-trip coach airfare)
2. Hotel accommodations: \$100 per day, for up to 21 days per trip, limited to one room (double occupancy)
3. Meals & miscellaneous expenses: \$25 per day for each person, for up to 21 days per trip

For the donor per transplant episode (limited to one trip per episode)

1. Transportation to transplant center: \$250 for round-trip coach airfare
2. Hotel accommodations: \$100 per day, for up to 7 days
3. Meals & miscellaneous expenses: \$25 per day, up to 7 days

**Calendar Year Deductible waived for Preferred Provider

Outpatient Prescription Drugs

Your financial responsibility for covered Prescription Drugs varies by the type of drug dispensed, and whether the drug was dispensed by a Participating Pharmacy or a Nonparticipating Pharmacy. See the “Definitions” section and the “Outpatient Prescription Drug Benefits” portion of the “Plan Benefits” and “General Limitations and Exclusions” sections for more information about what benefits are provided.

Benefit Maximums

	Maximum
Number of days per Prescription Drug Order for drugs from a retail pharmacy	30
Number of days per Prescription Drug Order for Maintenance Drugs through the Mail Order Program	90
Number of days per Prescription Drug Order for insulin needles and syringes from a retail Pharmacy	30
Number of days per Prescription Drug Order for blood glucose monitoring test strips and lancets from a retail Pharmacy	30

Notes:

- Drugs (including self-injectable medications) when Medically Necessary for treating sexual dysfunction are limited to quantities listed in the Recommended Drug List. Sexual dysfunction drugs are not available through the mail order program.
- Except for insulin, diabetic supplies (blood glucose testing strips, lancets, disposable needles & syringes) are packaged in 50, 100 or 200 unit packages. Packages cannot be “broken” (i.e. opened in order to dispense the product in quantities other than those packaged). When a prescription is dispensed, You will receive the size of package and/or number of packages required for You to test the number of times Your Physician has prescribed for a 30-day period.
- All benefits limited during a Covered Person's lifetime is the total amount of benefits offered under this plan, and shall apply to all Health Net or HNL plans sponsored by the same Group.

Copayments and Coinsurance

You will be charged a Copayment or Coinsurance for each Prescription Drug Order.

Retail Pharmacy

	<u>Participating Pharmacy</u>	<u>Nonparticipating Pharmacy</u>
Level I Drugs (primarily generic) when listed in the Recommended Drug List	\$15	\$15 (see "Notes")
Level II Drugs (primarily brand), insulin and diabetic supplies when listed in the Recommended Drug List	\$30	\$30 (see "Notes")
Level III Drugs (drugs not listed in the Recommended Drug List or listed as Level III Drugs)	\$30	\$30 (see "Notes")
Sexual dysfunction drugs (including injectable drugs)	50%	50%
Contraceptive devices	\$30	\$30 (see "Notes")

Maintenance Drugs through the Mandatory Mail Order Program

	<u>Mail Order Program</u>
Level I Drugs (primarily generic) when listed in the Recommended Drug List	\$30
Level II Drugs (primarily brand), insulin and diabetic supplies when listed in the Recommended Drug List	\$60
Level III Drugs (drugs not listed in the Recommended Drug List or listed as Level III Drugs)	\$60

Notes:

- **In addition to the Copayments listed above for Nonparticipating Pharmacies, You must also pay 50% of the Prescription Drug Covered Expense.**
- If the pharmacy's retail price is less than the applicable Copayment or Coinsurance, You will pay the pharmacy's retail price.
- If a Brand Name Drug is dispensed, and there is an equivalent Generic Drug commercially available, You will be required to pay the difference in cost between the Generic Drug and Brand Name Drug in addition to the Copayment shown above, unless the Physician has stated "Dispense As Written" or "Do Not Substitute" or words of similar meaning in the Physician's handwriting on the Prescription Drug Order.
- Some drugs may require Prior Authorization from HNL to be covered.
- In addition to the Copayments and Coinsurance shown above, You are responsible for charges billed in excess of the Prescription Drug Covered Expenses for all drugs dispensed by a Nonparticipating Pharmacy.
- Generic or Brand Name Drugs not listed in the Recommended Drug List which are prescribed by Your Physician and not excluded or limited from coverage are subject to the Level III Drug Copayment.
- Maintenance Drugs must be obtained through the mail order drug program. Please refer to the "Outpatient Prescription Drug Benefits" portion of "Plan Benefits" under the heading "Retail Pharmacies and the Mail Order Program." Maintenance Drugs may also be obtained at a CVS retail pharmacy under the mail order program benefits.
- Up to a 90-consecutive-calendar-day-supply of covered Maintenance Drugs will be dispensed at the applicable mail order Copayment or Coinsurance when ordered through HNL's contracted mail service vendor.
- Drugs (including injectable medications) when Medically Necessary for treating sexual dysfunction are limited to two doses per week or eight tablets per month. Sexual dysfunction drugs are not available through the mail order program.

- Schedule II narcotic drugs are not covered through mail order. Schedule II drugs are drugs classified by the Federal Drug Enforcement Administration as having a high abuse risk but also safe and accepted for medical uses in the United States.

ELIGIBILITY, ENROLLMENT AND TERMINATION

Who Is Eligible For Coverage

The Covered Services and Supplies of this plan are available to the following individuals as long as they live in the United States, and meet the additional eligibility requirements of the Group:

- You: The principal Covered Person (employee);
- Spouse: Your lawful spouse as defined by California law. (The term "spouse" also includes the principal Covered Person's Domestic Partner as defined)
- Children: The unmarried dependent children of You or Your spouse (including legally adopted children and stepchildren); and
- Wards: Children for whom You or Your spouse is a court-appointed guardian.

Children of You or Your spouse who are the subject of a Medical Child Support Order, according to state or federal law, are also eligible. Coverage of care received outside the United States will be limited to services provided in connection with Emergency Care.

Age Limit for Children

Each child is eligible until the age of 26 (the limiting age).

Disabled Child

A child who reaches the age limit shown above is eligible to continue coverage if **all** of the following conditions apply:

- The child is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition; and
- The child is chiefly dependent upon the principal Covered Person for support and maintenance.

If You are *enrolling* a disabled child for new coverage, You must provide HNL with proof of incapacity and dependency within 60 days of the date You receive a request for such information about the dependent child from HNL. The child must have been covered as a dependent of the principal Covered Person or spouse under a previous group health plan at the time the child reached the age limit.

HNL must provide You notice at least 90 days prior to the date Your enrolled child reaches the age limit at which the dependent child's coverage will terminate. You must provide HNL with proof of Your child's incapacity and dependency within 60 days of the date You receive such notice from HNL in order to continue coverage for a disabled child past the age limit.

You must provide the proof of incapacity and dependency at no cost to HNL.

A disabled child may remain covered by this plan for as long as he or she remains incapacitated and continues to meet the eligibility criteria described above.

How to Enroll for Coverage

Notify the Group that You want to enroll an eligible person. The Group will send the request to HNL according to current procedures.

Employee

Each new employee entering employment subsequent to the Effective Date of the Group's initial enrollment period shall be permitted, without proof of insurability, to apply for coverage for himself or herself and eligible Dependents within 60 days of becoming eligible, subject to the enrollment regulations in effect with the Group. Such enrollments, if accepted by HNL, become effective when any waiting or probationary period required by the Group is completed.

When the employee is not subject to a probationary period, the enrollment becomes effective, in accordance with established Group eligibility rules, either on the date of hire or on the first day of the pay period following the date of meeting the County's eligibility requirements.

Eligible employees who enroll in this plan are called principal Covered Persons.

Newly Acquired Dependents

You are entitled to enroll newly acquired dependents as follows:

Spouse: If You marry while You are covered by this plan, You may enroll Your new spouse (and Your spouse's eligible children) within 60 days of the date of marriage. Coverage begins either on the date of marriage or on the first day of the pay period following the date of meeting the County's eligibility requirements.

Domestic Partner: If You are the principal Covered Person and You enter into a domestic partnership while You are covered by this plan, You may enroll Your new Domestic Partner (and his or her eligible children) within 60 days of the date a Declaration of Domestic Partnership is filed with the Secretary of State or other recognized state or local agency, or within 60 days of the formation of the domestic partnership according to Your Group's eligibility rules. Coverage begins either on the date the Domestic Partnership is filed or formed, or on the first day of the pay period following the date of meeting the County's eligibility requirements.

Newborn Child: Coverage for newborn children will be effective upon birth and during the first 60 days following birth. However, coverage after 60 days is contingent upon You enrolling the newborn within 60 days following birth.

Adopted Child: A newly adopted child or a child who is being adopted, becomes eligible on the date the appropriate legal authority grants You or Your spouse, in writing, the right to control the child's health care.

Coverage begins automatically and will continue for 60 days from the date of eligibility. You must enroll the child before the 59th day for coverage to continue beyond the first 60 days. Your Employer will require written proof of the right to control the child's health care when such child is enrolled.

Legal Ward (Guardianship): If You or Your spouse become the legal guardian of a child, the child is eligible to enroll on the effective date of the court order, but coverage is not automatic. The child must be enrolled within 60 days of the effective date of the guardianship. Coverage will begin on the first day of the month after HNL receives the enrollment request.

Your Employer will require proof that You or Your spouse is the court-appointed legal guardian.

Open Enrollment Period

An Open Enrollment Period shall be held annually, at which time potential Covered Persons may enroll under this *Certificate*. Upon receipt of enrollment changes and corresponding payment of dues for an enrollment, such enrollment changes shall, if accepted by HNL, become effective on the first day of the pay period coinciding with the contract renewal date for which the change is submitted, unless otherwise approved by HNL.

Late Enrollment Rule

HNL's late enrollment rule requires that if an individual does not enroll within 60 days of becoming eligible for coverage, he or she must wait until the next Open Enrollment Period to enroll. (Time limits for enrolling are explained in the "Employee" and "Newly Acquired Dependents" provision above.)

The term "form" within this section may include electronic enrollment forms or enrollment over the phone. Electronic or phone enrollments are deemed signed when You use Your employer's enrollment system to make or confirm changes to Your benefit enrollment.

A Late Enrollee may be excluded from coverage for until the next Open Enrollment.

You may have decided not to enroll upon first becoming eligible. At that time, the Group should have given You a form to review and sign. It would have contained information to let You know that there are circumstances when You will not be considered a late enrollee.

If You later change Your mind and decide to enroll, HNL can impose its late enrollment rule. This means that individuals identified as declining coverage on the form the employee signed will not be allowed to enroll before the next Open Enrollment Period. There are, however, exceptions to this rule.

Exceptions to Late Enrollment Rule

If any of the circumstances below are true, the late enrollment rule will not apply.

1. You Did Not Receive a Form To Sign or A Signed Form Cannot Be Produced

If You chose not to enroll when first eligible, the late enrollment rule will not apply to You:

- If You never received from the Group or signed a form explaining the consequences of Your decision; or
- Your signed form exists but cannot be produced as evidence of Your informed decision.

2. You Did Not Enroll Because of Other Coverage and Later the Other Coverage is Lost

If You declined coverage in this plan, and You stated on the form the reason You were not enrolling was because of coverage through another group health plan, and the other coverage is or will be lost for any of the following reasons, the late enrollment exclusion will not apply to You:

- The principal enrollee of the other plan has ceased being covered by that other plan, (except for either failure to pay premium contributions, or a “for cause” termination, such as fraud or misrepresentation of an important fact);
- Loss of coverage because of termination of employment or reduction in the number of hours of employment;
- Loss of coverage through an HMO or other individual arrangement because an individual ceases to reside, live or work in the service area;
- Loss of coverage through an HMO or other arrangement in the group market because an individual ceases to reside, live or work in the service area, and no other benefit package is available to the individual;
- The other plan was terminated and not replaced with other Group coverage;
- The other Group stops making contributions toward employee's or dependent's coverage;
- When an individual incurs a claim that would meet or exceed a lifetime limit on all benefits;
- When the individual's plan ceases to offer any benefits to the class of similarly situated individuals that includes the individual;
- The other principal enrollee or employee dies;
- The principal enrollee and spouse are divorced or legally separated and this causes loss of the Group coverage;
- Loss of coverage because cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan); or
- The other coverage was federal COBRA or Small Employer Cal-COBRA, and the period of coverage ends.

3. You Lose Eligibility from a Children’s Health Insurance Program (CHIP) Plan (Known in California as the Healthy Families Program), Access for Infants or Mothers Program (AIM) or a Medi-Cal Plan

CHIP is a joint federal and state program that provides comprehensive health care coverage for children under the age of 19. In California, the CHIP plan is known as the Healthy Families Program. If You become ineligible and lose coverage under the Healthy Families Program, the Access for Infants or Mothers Program (AIM), or Medi-Cal, You and/or Your Dependent(s) will be eligible to enroll in this plan upon submitting a completed application form within 60 days of losing such coverage. If You and/or Your Dependent(s) wait longer than 60 days to enroll, You and/or Your Dependent(s) may not enroll until the next Open Enrollment period.

4. Multiple Health Plans

If You are enrolled as a dependent in a health plan (not HNL), and the enrollee of that other plan, during open enrollment, chooses a different type of plan (such as moving from an HMO plan to a fee-for-service plan), and You do not wish to continue to be covered by the original plan, You will not be considered a late enrollee, should You decide to enroll in this plan.

5. Court Orders

If a court orders You to provide coverage for a current spouse (not a former spouse), or orders You or Your enrolled spouse to provide coverage to a minor child through HNL, that spouse or child will not be treated as a late enrollee.

If the exceptions in 2 or 4 apply, You must enroll within 60 days of the loss of coverage. If You wait longer than 60 days to enroll, You will be a late enrollee and may not enroll until the next Open Enrollment Period. A court ordered dependent may be added without any regard to Open Enrollment restrictions .

Special Enrollment Rule For Newly Acquired Dependents

If an employee gains new dependents due to childbirth, adoption or marriage the following rules apply:

If the Employee Is Enrolled in this Plan

If You are covered by this plan as an employee of the Group, You can enroll a new dependent if You request enrollment within 60 days after childbirth, marriage or adoption. In addition, a court ordered dependent may be added without any regard to open enrollment restrictions.

More information about enrolling new dependents and their Effective Date of coverage is available above under the heading "How to Enroll For Coverage" and subheading "Newly Acquired Dependents."

If the Employee Declined Enrollment in this Plan

If You previously declined enrollment in this plan because of other Group coverage, and You gain a new dependent due to childbirth, marriage, adoption or placement for adoption, You can enroll yourself and the dependent within 60 days of childbirth, marriage, adoption or placement for adoption.

If you gain a new dependent due to a court order and you did not previously enroll in this plan, you may enroll yourself and your court ordered dependent(s) without any regard to open enrollment restrictions.

In addition any other family members who are eligible for coverage may enroll at the same time as You and the new dependent. You no longer have to wait for the next Open Enrollment Period, and whether or not You are covered by another Group plan has no effect on this right.

If You do not enroll yourself, the new dependent and any other family members within 60 days of acquiring the new dependent, You will have to wait until the next Open Enrollment Period to do so.

The Effective Date of coverage for You and all Dependents who enroll within 60 days of childbirth, marriage, adoption or placement for adoption will be the same as for the new dependent.

- In the case of childbirth, the Effective Date will be the moment of birth;
- For marriage, the Effective Date will be either on the date of marriage or the first day of the pay period following the date of marriage, according to the rules established by the Group;
- Regarding adoption, the Effective Date will be the date the birth parent or appropriate legal authority grants the employee or his or her spouse, in writing, the right to control the child's health care; and
- In the case of a Medical Child Support Order, the Effective Date will be the date the Group is notified of the court order.

Note: When You are not enrolled in this plan, and You wish to have coverage for a newborn or adopted child who is ill, please contact the Group as soon as possible and ask that You (the employee) and the newborn be enrolled. You must be enrolled in order for Your eligible Dependent to be enrolled.

While You have 60 days within which to enroll the child, until You and Your child are formally enrolled and recorded as Covered Persons in HNL's computer system, We cannot verify coverage to any inquiring medical provider.

Special Reinstatement Rule For Reservists Returning From Active Duty

Reservists ordered to active duty on or after January 1, 2007 who were covered under this *Certificate* at the time they were ordered to active duty and their eligible dependents will be reinstated without waiting periods. A

reservist means a member of the U.S. Military Reserve or California National Guard called to active duty as a result of the Iraq conflict pursuant to Public Law 107-243 or the Afghanistan conflict pursuant to Presidential Order No. 13239. Please notify the Group when You return to employment if You want to reinstate Your coverage under the *Certificate*.

Special Reinstatement Rule Under USERRA

USERRA, a federal law, provides service members returning from a period of uniformed service who meet certain criteria with reemployment rights, including the right to reinstate their coverage waiting periods, subject to certain restrictions. Please check with Your Group to determine if You are eligible.

Replacement Of Coverage Provision

This provision applies only to persons covered under the Employer's prior group plan ("Prior Plan") on the date it canceled and who are eligible for coverage under this *Certificate* on its effective date. The Prior Plan must be replaced by this *Certificate* within 60 days.

All persons covered under the Prior Plan are covered under this *Certificate*. However, some benefits of this *Certificate* may be reduced or denied. These benefits are described below:

Any covered medical charges used to satisfy Deductible or out-of-pocket requirements under the Prior Plan during the Calendar Year of the plan change, may be counted toward satisfying them under this Policy.

If a person is totally disabled and extended benefits are payable under the Prior Plan, no benefits are payable under this *Certificate* for the condition that caused the Total Disability.

If a person remains totally disabled, benefits are payable under this *Certificate* until the earlier of the following:

- 12 months from the date the Prior Plan stopped; or
- the date the benefits would otherwise stop under this *Certificate*.

Certain children will be included as Dependents eligible for health coverage under this *Certificate* regardless of age. The child must have been covered under the Prior Plan. The child must meet the following conditions:

- the child is mentally or physically handicapped;
- the child is not capable of self-support; and
- the child depends mainly on You for support.

You must give proof to HNL that the child meets these conditions, when requested.

When Coverage Ends

You must notify the Group of changes that will affect Your eligibility. The Group will send the appropriate request to HNL according to current procedures. HNL is not obligated to notify You that You are no longer eligible or that Your coverage has been terminated.

All Covered Persons

All Covered Persons of a Group become ineligible for coverage under this *Certificate* at the same time if the Policy (between the Group and HNL) is terminated, including termination due to nonpayment of premiums by the Group.

Principal Covered Person and All Dependents

The principal Covered Person and all his or her Dependents will become ineligible for coverage at the same time if the principal Covered Person loses eligibility for this plan.

Individual Covered Persons

Individual Covered Persons become ineligible on the date any of the following occurs:

- The Covered Person no longer meets the eligibility requirements established by the Group and HNL. This will include a child subject to a Medical Child Support Order, according to state or federal law, who becomes ineligible on the earlier of:
 1. The date established by the order; or

2. The date the order expired.

- The Covered Person establishes primary residency outside the United States;
- The Covered Person becomes eligible for Medicare and assigns Medicare benefits to another health maintenance organization or competitive medical plan;
- A Covered Person becomes a legally emancipated minor according to state law; or
- Your marriage or domestic partnership ends by divorce, annulment or some other form of dissolution. Eligibility for Your enrolled spouse (now former spouse) and that spouse's enrolled dependents, who were related to You only because of the marriage, will end.

Notice Of Ineligibility

It shall be Your responsibility to notify the Group of any changes that will affect Your eligibility or that of Your Dependents for services or benefits under this *Certificate*. HNL shall have no obligation to provide notification of ineligibility or termination of coverage to individual Covered Persons.

Coverage Options Following Termination

Please examine Your options carefully before declining coverage. You should be aware that companies selling individual health insurance typically require a review of Your medical history that could result in a higher premium or You could be denied coverage entirely.

If coverage through this *Certificate* ends, the terminated Covered Person may be eligible for additional periods of coverage under this or other types of plans through HNL as follows:

COBRA Continuation Coverage

Many Groups are required to offer continuation coverage by the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). For most groups with 20 or more employees, COBRA applies to employees and their eligible dependents, even if they live outside California. Please check with the Group to determine if You and Your Dependents are eligible for COBRA continuation.

Cal-COBRA Continuation Coverage

If You have exhausted COBRA and You live in the United States, You may be eligible for additional continuation coverage under state Cal-COBRA law. This coverage may be available if You began receiving federal COBRA coverage on or after January 1, 2003, have exhausted federal COBRA coverage, have had less than 36 months of COBRA coverage and You are not entitled to Medicare. If You are eligible, You have the opportunity to continue group coverage under this *Certificate* through Cal-COBRA for up to 36 months from the date that federal COBRA coverage began.

HNL Will Offer Cal-COBRA to Covered Persons: HNL will send Covered Persons whose federal COBRA coverage is ending information on Cal-COBRA rights and obligations along with the necessary premium information, enrollment forms, and instructions to formally choose Cal-COBRA Continuation Coverage. This information will be sent by U.S. mail with the notice of pending termination of federal COBRA.

Choosing Cal-COBRA: If an eligible Covered Person wishes to choose Cal-COBRA Continuation Coverage, he or she must deliver the completed enrollment form (described immediately above) to HNL by first class mail, personal delivery, express mail, or private courier company. The address appears on the back cover of this *Certificate*.

The Covered Person must deliver the enrollment form to HNL within 60 days of the later of (1) the Covered Person's termination date for COBRA coverage or (2) the date he or she was sent a notice from HNL that he or she may qualify for Cal-COBRA Continuation.

Payment for Cal-COBRA: The Covered Person must pay HNL 110% of the applicable group rate charged for employees and their dependents.

The Covered Person must submit the first payment within 45 days of delivering the completed enrollment form to HNL in accordance with the terms and conditions of the health plan contract. The first payment must cover the period from the last day of prior coverage to the present. There can be no gap between prior coverage and Cal-COBRA Continuation Coverage. The Covered Person's first payment must be delivered to HNL by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company. If the payment covering the period from the last day of prior coverage to the present is not received within 45 days of providing the enrollment form to HNL, the Covered Person's Cal-COBRA election is not effective and no coverage is provided.

All subsequent payments must be made on the first day of each month. If the payment is late, the Covered Person will be allowed a grace period of 60 days. Fifteen days from the due date (the first of the month), HNL will send a letter warning that coverage will terminate 15 days from the date on the letter. If the Covered Person fails to make the payment within 15 days of the notice of termination, enrollment will be canceled by HNL. If the Covered Person makes the payment before the termination date, coverage will be continued with no break in coverage. Amounts received after the termination date will be refunded to the Covered Person by HNL within 20 business days.

Employer Replaces Previous Plan: There are two ways the Covered Person may be eligible for Cal-COBRA Continuation Coverage if the employer replaces the previous plan:

If the Covered Person had chosen Cal-COBRA Continuation Coverage through a previous plan provided by his or her current employer and replaced by this plan because the previous policy was terminated, or

If the Covered Person selects this plan at the time of the employer's open enrollment.

The Covered Person may choose to continue to be covered by this plan for the balance of the period that he or she could have continued to be covered by the prior group plan. In order to continue Cal-COBRA coverage under the new plan, the Covered Person must request enrollment and pay the required premium within 31 days of receiving notice of the termination of the prior plan. If the Covered Person fails to request enrollment and pay the premium within the 31-day period, Cal-COBRA Continuation Coverage will terminate.

Employer Replaces this Plan: If the Policy between HNL and the employer terminates, coverage with HNL will end. However, if the employer obtains coverage from another insurer or HMO, the Covered Person may choose to continue to be covered by that new plan for the balance of the period that he or she could have continued to be covered by the HNL plan.

When Does Cal-COBRA Continuation Coverage End? When a Qualified Beneficiary has chosen Cal-COBRA Continuation Coverage, coverage will end due to any of the following reasons:

1. You have been covered for 36 months from Your original COBRA effective date (under this or any other plan)*.
2. The Covered Person becomes entitled to Medicare, that is, enrolls in the Medicare program.
3. The Covered Person moves outside the United States.
4. The Covered Person fails to pay the correct premium amount on the first day of each month as described above under "Payment for Cal-COBRA."
5. Your Group's Policy with HNL terminates. (See "Employer Replaces this Plan.")
6. The Covered Person becomes covered by another group health plan that does not contain a pre-existing condition limitation preventing the individual from receiving the full benefits of that plan.

If the Covered Person becomes covered by another group health plan that does contain a pre-existing condition limitation preventing the individual from receiving the full benefits of that plan, coverage through this plan will continue. Coordination of Benefits will apply, and Cal-COBRA plan will be the primary plan.

*The COBRA effective date is the date the Covered Person first became covered under COBRA continuation coverage.

USERRA Coverage

Under a federal law known as the Uniformed Services Employment and Reemployment Rights Act (USERRA), employers are required to provide employees who are absent from employment to serve in the uniformed services and their dependents who would lose their group health coverage the opportunity to elect continuation coverage for a period of up to 24 months. Please check with Your Group to determine if You are eligible.

Extension of Benefits

Described below in the subsection titled "Extension of Benefits."

Conversion Coverage

Described below in the subsection titled "Conversion Coverage."

Continuation Of Coverage During A Labor Dispute

If You cease to work because of a labor dispute and Your Employer is paying all or a portion of the premium for Your coverage pursuant to the terms of a collective bargaining agreement, You may continue Your coverage subject to the following terms and conditions:

- Continuation of coverage requires:
 1. Your payment to the union which represents You of the monthly premium required for this coverage;
 2. The union collecting such payments from at least 75% of the persons who cease to work because of the labor dispute; and
 3. The timely payment of premiums to Us by the union or unions as required under the Policy for proper payment of premiums.
- If any premium due is unpaid on the date work ceases, there will be no continuation unless such premium is paid by Your Employer or the union prior to the next premium due date.
- The amount of Your monthly payment for continued coverage will be equal to the full group monthly cost for the coverage, including any portion usually paid by the Employer, and, except as provided in the bullet item immediately below, such premium rate will be the applicable rate then in effect for coverage under the Policy, on the date work ceases.
- The premium rates for coverage may be increased by 20% on the premium due date on or next after the date work ceases due to the labor dispute. Such increase will apply during the time coverage is continued under this provision. We still have the right to increase the premium rates before, during and after the date work ceases, if We would have had the right to increase rates under the Policy, had work not ceased.
- Your continued coverage under this provision will cease on the earliest of:
 1. The end of the period of time for which the union has made payment for Your coverage, if the next premium due is not made;
 2. The premium due date for which premiums are received for less than 75% of the persons eligible to continue coverage because of the labor dispute;
 3. The premium due date on or following the date that You start full-time work with another Employer;
 4. The premium due date on or after the date You ceased to be at work because of the labor dispute for 6 months; or
 5. The premium due date on or after the labor dispute is resolved.
- If You have Dependents insured on the date You cease work, You must also continue their coverage in order to continue coverage for You.

HIPAA

The federal Health Insurance Portability and Accountability Act (HIPAA) makes it easier for people covered under existing group health plans to maintain coverage regardless of pre-existing conditions when they change jobs or are unemployed for brief periods of time. California law provides similar and additional protections. Applicants who meet the following requirements are eligible to enroll in a guaranteed issue individual health plan from any health plan that offers individual coverage without medical underwriting. A health plan cannot reject Your application for guaranteed issue individual health coverage if You meet the following requirements, agree to pay the required premiums and live or work in the plan's service area. Specific Guaranteed Issue rates apply. Only eligible individuals qualify for guaranteed issuance. To be considered an eligible individual:

- The applicant must have a total of 18 months of coverage (including COBRA, if applicable) without a significant break (excluding any employer-imposed waiting periods) in coverage of more than 63 days.

- The most recent coverage must have been under a group health plan. COBRA and Cal-COBRA coverage are considered group coverage.
- The applicant must not be eligible for coverage under any group health plan, Medicare or Medicaid, and must not have other health insurance coverage.
- The individual's most recent coverage could not have been terminated due to fraud or nonpayment of premiums.
- If COBRA or Cal-COBRA coverage was available, it must have been elected and such coverage must have been exhausted.

For more information regarding guarantee issue coverage through HNL, please call Our Individual Sales Department at **1-800-909-3447**. If You believe Your rights under HIPAA have been violated, please contact the Department of Insurance at **1-800-927-HELP**.

Extension of Benefits

If You are totally disabled when the Group Policy ends and are under the treatment of a Physician, the benefits of this *Certificate* may continue to be provided for services treating the totally disabling illness or injury. No benefits are provided for services treating any other illness, injury or condition.

You must submit a written request for these total disability benefits, which must include written certification by Your Physician that You are totally disabled. HNL must receive this certification within 90 days of the date coverage ends under this *Certificate*. At least once every 90 days while benefits are extended, HNL must receive proof that Your total disability is continuing. It shall be Your responsibility to ensure that HNL is notified of any requested extension of benefits prior to the required 90 day intervals. Benefits are provided until whichever of the following occurs first:

- You are no longer totally disabled;
- The maximum benefits of this *Certificate* are paid;
- You become covered under another group health plan that provides coverage without limitation on the disabling illness or injury; or
- A period of 12 consecutive months has passed since the date coverage ended.

For the purpose of this extension, You shall be considered totally disabled when, as a result of bodily injury or disease, You are unable to engage in any employment or occupation for which he or she is or becomes qualified by reason of education, training or experience and not, engaged in any employment or occupation for wage or profit. A Dependent shall be considered totally disabled when he or she is prevented from performing all regular and customary activities usual for a person of that age and family status.

How to Obtain an Extension Member Is Confined to a Hospital

If you are confined to a Hospital or Skilled Nursing Facility when your coverage ends, benefits will be extended to you automatically. You do not have to do anything to make it happen.

When you are discharged from a Hospital or Skilled Nursing Facility, no further extension is available, unless your coverage ended because the Group Service Agreement ended.

If your coverage ended because the Group Service Agreement between Health Net and the Group was terminated and you are totally disabled and want to continue to have extended benefits, you must send a written request to Health Net within ninety (90) days of the discharge date. The request must include your Physician Group's written certification that you are totally disabled.

Member Is *Not* Confined to a Hospital

If a Member is totally disabled and not confined to a Hospital or Skilled Nursing Facility when the Agreement ends, send a written request to Health Net within 90 days of the date the Agreement terminates. The request must include written certification by the Member's Physician Group that the Member is totally disabled.

If benefits are extended because of total disability, provide Health Net with proof of total disability at least once every 90 days during the extension. The Member must ensure that Health Net receives this proof before the end of each 90-day period.

When the Extension Ends

The Extension of Benefits will end on the *earliest* of the following dates:

For extensions provided only because of Hospital confinement: If the Agreement between Health Net and the Group has not been terminated, then the Extension of Benefits will end on the earliest of the following dates:

- On the date the Member is discharged from the Hospital or Skilled Nursing Facility, even if the total disability continues.
- On the date the Member becomes covered by another private or group health insurance policy or plan.
- On the date that available benefits are exhausted.

For extensions provided because of total disability which may or may not involve hospitalization: If the Agreement between Health Net and the Group has been terminated, then the extension of benefits will end on the earliest of the following dates:

- On the date the Member is no longer totally disabled;
- On the date the Member becomes covered by a replacement health policy or plan obtained by the Group and this coverage has no limitation for the disabling condition;
- On the date that available benefits are exhausted; or
- On the last day of the 12-month period following the date the extension began, unless the Member is confined in a Hospital or Skilled Nursing Facility on that date for the disabling condition.

Other Coverage Affecting Extension of Benefits

Other Group Coverage

Extended benefits will end as stated in the section immediately above titled "When the Extension Ends."

If other group coverage exists that does not cause the extension of benefits to end, such as coverage through a new job or coverage that existed before the loss of Health Net coverage, Health Net will obtain reimbursement from the other plan through the Coordination of Benefits process.

Also, when another health maintenance organization (HMO) provides that coverage, Health Net may arrange for that HMO to be responsible for continuing medical care.

COBRA Continuation Coverage

If your Health Net coverage continues because you were eligible for and obtained federal COBRA continuation coverage, you have not yet lost your Health Net coverage. If you are still totally disabled when the COBRA continuation coverage ends, you may try to obtain an extension as described above in the section titled "How to Obtain an Extension."

Conversion Coverage

Conversion coverage affects extension of benefits when:

- You receive an extension of the benefits of this Plan; and
- You have also elected conversion coverage and it is in force.

Whichever coverage provides the higher benefits will be applied toward the disabling condition. Refer to "Conversion Privilege" section immediately below.

Other Coverage Affecting Extension of Benefits

Other Group Coverage

Extended benefits will end as stated in the section immediately above titled "When the Extension Ends."

If other group coverage exists that does not cause the extension of benefits to end, such as coverage through a new job or coverage that existed before the loss of Health Net coverage, Health Net will obtain reimbursement from the other plan through the Coordination of Benefits process.

Also, when another health maintenance organization (HMO) provides that coverage, Health Net may arrange for that HMO to be responsible for continuing medical care.

COBRA Continuation Coverage

If your Health Net coverage continues because you were eligible for and obtained federal COBRA continuation coverage, you have not yet lost your Health Net coverage. If you are still totally disabled when the COBRA continuation coverage ends, you may try to obtain an extension as described above in the section titled "How to Obtain an Extension."

Conversion Coverage

Conversion coverage affects extension of benefits when:

- You receive an extension of the benefits of this Plan; and
- You have also elected conversion coverage and it is in force.

Whichever coverage provides the higher benefits will be applied toward the disabling condition. Refer to "Conversion Privilege" section immediately below.

Conversion Coverage

Benefits and premiums under a conversion agreement are not the same as those provided under this Certificate.

Who Is Eligible For Conversion Coverage

All Covered Persons covered under this *Certificate* are entitled to obtain conversion coverage if the reason for loss of this Group coverage is:

- The Group Policy between HNL and the Group was terminated, whether such termination was initiated by the Group or HNL and regardless of the reasons for termination; or
- The Covered Person lost the eligibility for coverage as described in this "Eligibility, Enrollment and Termination" section of this *Certificate* with the exceptions as noted below.

Who Is Not Eligible For Conversion Coverage

- Your Dependents who were not covered under this *Certificate* when Your coverage ends; or
- Covered Persons who have coverage under any other individual or Group policy.

How to Apply for Conversion Coverage

You must request and complete an application form and send it to HNL within 63 days of the last day of coverage.

Anyone eligible to enroll in the HNL conversion plan who does not enroll when Group coverage ends, will not be allowed to do so at a later date.

Conversion coverage must become effective immediately following the date Group coverage ends. There can be no lapse in coverage. The Covered Person must pay all required premiums to ensure that coverage is continuous.

PLAN BENEFITS

The services and supplies described below will be covered for the Medically Necessary treatment of a covered illness, injury or condition. These benefits are subject to all provisions of this *Certificate*.

In addition, many of the Covered Services and Supplies listed herein are subject to Certification in many instances, prior to the expenses being incurred. If Certification is not obtained, the available benefits will be reduced. Please refer to the "Certification Requirement" subsection for further details.

An expense is incurred on the date You receive the service or supply for which the charge is made. HNL shall not pay for expenses incurred for any services or supplies in excess of any visit or benefit maximum described in the "Schedule of Benefits" section or elsewhere in this *Certificate*, nor for any service or supply excluded herein.

Services by certain providers may be covered only when a medical doctor (M.D.) or doctor of osteopathy (D.O.) refers You to them. Please refer to the definition of "Physician" in the "Definitions" section for more information.

The fact that a Physician or other provider may perform, prescribe, order, recommend or approve a service, supply or hospitalization does not, in itself, make it Medically Necessary, or make it a covered service.

How Covered Expenses Are Determined

HNL will pay for Covered Expenses You incur under this plan. Covered Expenses are based on the maximum charge HNL will accept from each type of provider, not necessarily the amount a Physician or other health care provider bills for the service or supply. Other limitations on Covered Expenses may apply. See "Schedule of Benefits," "Plan Benefits" and "General Limitations and Exclusions" sections for specific benefit limitations, maximums, pre-certification requirements and surgery payment policies that limit the amount HNL pays for certain Covered Services and Supplies.

Preferred Providers

The maximum amount of Covered Expenses for a service or supply provided by a Preferred Provider is the lesser of the billed charge or the amount contracted in advance by HNL, referred to in this *Certificate* as the Contracted Rate.

Since the Preferred Provider has agreed to accept the Contracted Rate as payment in full, You will not be responsible for any amount billed in excess of the Contracted Rate. However, You are responsible for any applicable Deductible(s), Copayments or Coinsurance payment required. You are always responsible for services or supplies not covered by this plan.

Out-of-Network Provider

The maximum amount HNL will pay for Covered Expenses when services or supplies are received from an Out-of-Network Provider is the lesser of the billed charge or the Maximum Allowable Amount as defined in the "Definitions" section.

Since the Out-of-Network Provider has **not** agreed to accept the Maximum Allowable Amount as payment in full, the amount billed by the Out-of-Network Provider may exceed the Maximum Allowable Amount. You will need to pay that excess amount, in addition to any applicable Deductible(s), Copayments or Coinsurance payment required. You are always responsible for services or supplies not covered by this plan. Once the Maximum Allowable Amount is determined, the amount that HNL pays on Out-of-Network Provider and the amount which will be your responsibility are determined as follows:

- HNL pays an Out-of-Network Provider an amount equal to the Maximum Allowable Amount, less any Deductible(s), Copayments and/or Coinsurance applicable to the Covered Expense for the service or supply that You receive.
- The portion of the Maximum Allowable Amount that will be Your responsibility is any Deductible(s), Copayments and/or Coinsurance applicable to the Covered Expense for the service or supply that You receive.
- Unless the Out-of-Network Provider has agreed to accept the Maximum Allowable Amount as payment in full, as described in the definition of Maximum Allowable Amount, the amount billed by the Out-of-Network Provider may exceed the Maximum Allowable Amount. You will be responsible for that excess amount, in

addition to any applicable Deductible(s), Copayments and/or Coinsurance payment required. In addition, You are always responsible for services or supplies not covered by this plan.

Important Note: Even if a Hospital is a Preferred Provider, You should not assume that all Physicians and other individual providers of health care at the Hospital are Preferred Providers. If You are admitted to a Hospital You should request that all services be performed by Preferred Providers whenever You enter a Hospital.

Deductibles

- After HNL determines the amount of Covered Expenses, HNL will subtract the applicable Deductible(s) and either the Copayment or the Coinsurance that applies to the covered service or supply. HNL will then pay up to the benefit limit shown in the "Schedule of Benefits" section.
- Only Covered Expenses will be applied to the satisfaction of the Deductible(s) shown in this *Certificate*.
- There may also be Deductibles in addition to the Calendar Year Deductible that You may need to pay, depending on the services or supplies received. Please check the "Deductibles" portion of the "Schedule of Benefits" section for details. Each Deductible is separate and distinct from the other, and Covered Expenses applied to one Deductible will not be applied to any other Deductible of this plan, except that a Calendar Year Deductible will be applied toward the satisfaction of the family Deductible, as set forth below.
- Covered Expenses incurred under this plan in the last three months of a Calendar Year, used to satisfy this plan's Calendar Year Deductible for that year, may also be used to satisfy the Calendar Year Deductible for the following Calendar Year.
- Prior Deductible carryover credit applies if this Policy is replacing a similar policy that had been issued to the Group Policyholder. If a Covered Person has satisfied any portion of the Deductible under the prior carrier plan, the credit shall apply to the satisfaction of the Covered Person's initial Calendar Year Deductible under this *Certificate*. Proof of Deductible satisfaction under the prior carrier plan will be required upon submission of the initial claim for benefits to be payable under this *Certificate*.
- There are two additional Deductibles which will apply when You use the services of a Hospital or Skilled Nursing Facility through an Out-of-Network Provider. The Out-of-Network inpatient Deductible will apply for each admission to a Hospital, the Skilled Nursing Facility, and the Out-of-Network outpatient surgery Deductible will apply to any surgical session performed in either the outpatient section of a Hospital and the Skilled Nursing Facility inpatient, or in an Ambulatory Surgical Center.

These Deductibles will not apply when You go to a Preferred Provider.

- If You go to an emergency room, You must pay the emergency room Deductible. If You go to an urgent care center, You must pay the urgent care center Deductible. These Deductibles apply regardless of whether You go to a Preferred Provider or to an Out-of-Network Provider. However, You will not have to pay these Deductibles if You are admitted as an inpatient directly to the Hospital.
- Expenses incurred under the Prescription Drug Benefit are not applied to the Calendar Year or additional Deductible(s).

Out-of-Pocket Maximum

When Your total medical Copayments or Coinsurance payments, during any Calendar Year, equal the Out-of-Pocket Maximum set forth in the "Schedule of Benefits" section, no further Copayments or Coinsurance will be required from You for the remainder of that Calendar Year. (See the "Schedule of Benefits" section for exceptions.)

Except for exceptions noted in the "Schedule of Benefits" section, Copayments or Coinsurance paid for the services of a Preferred Provider will apply toward the Out-of-Pocket Maximum for Out-of-Network Providers. Similarly, Coinsurance paid for the services of an Out-of-Network Provider will apply toward the Out-of-Pocket Maximum for Preferred Providers.

Medical Lifetime Benefit Maximum

All medical benefits are limited to the maximum set forth in the “Schedule of Benefits” section during each Covered Person’s lifetime. This amount applies to each Covered Person for all Health Net or HNL plans sponsored by the same Group.

Certification Requirement

Some of the Covered Expenses under this plan are subject to a requirement of Certification in order for full benefits to be available. All Certifications are performed by HNL.

Certification is NOT a determination of benefits. Some of these services or supplies may not be covered under Your Plan. Even if a service or supply is certified, eligibility rules and benefit limitations will still apply.

Services Requiring Certification

- Inpatient admissions
Any type of facility, including but not limited to:
 1. Hospital
 2. Skilled Nursing Facility
 3. Mental health facility
 4. Chemical dependency facility
 5. Acute rehabilitation center
 6. Hospice
- Surgical procedures including:
 1. Abdominal, ventral, umbilical, incisional hernia repair
 2. Bariatric procedures
 3. Blepharoplasty
 4. Breast reductions and augmentations
 5. Rhinoplasty
 6. Sclerotherapy
 7. Uvulopalatopharyngoplasty (UPPP) and laser assisted UPPP
 8. Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate
- Organ, tissue and stem cell transplant services, including pre-evaluation and pre-treatment services and the transplant procedure
- Home Health Care Services including nursing, physical therapy, occupational therapy, speech therapy, home I.V. therapy and home uterine monitoring
- Certain Physician-administered drugs, whether administered in a Physician office, free-standing infusion center, ambulatory surgery center, outpatient dialysis center, or outpatient hospital. Refer to the Health Net Life website, www.healthnet.com, for a list of Physician-administered drugs that require Certification.
- Hospice Care
- Outpatient Diagnostic Imaging:

1. CT (Computerized Tomography)
 2. MRA (Magnetic Resonance Angiography)
 3. MRI (Magnetic Resonance Imaging)
 4. MUGA (Cardian Scan (Multiple Gated Acquisition))
 5. PET (Positron Emission Tomography)
 6. SPECT (Single Photon Emission Computed Tomography)
- Durable Medical Equipment:
 1. Power wheelchairs
 2. Scooters
 3. Hospital beds
 4. Custom-made items
 - Prosthesis and orthotics over \$2,500
 - Air Ambulance
 - Tocolytic services (intravenous drugs used to decrease or stop uterine contractions in premature labor)
 - Orthognathic procedures (surgery performed to correct or straighten jaw and/or other facial bone misalignments to improve function), including TMJ treatment
 - Self-injectable drugs
 - Clinical trials
 - Bariatric-related services:
 1. Non-surgical bariatric-related consultations and services
 2. All bariatric-related surgical services

HNL will consider the Medical Necessity of Your proposed treatment, Your proposed level of care (inpatient or outpatient) and the duration of Your proposed treatment.

In the event of an admission to a Hospital, a concurrent review of the hospitalization will be performed. Confinement in excess of the number of days initially approved must be authorized by HNL.

Exceptions

Certification is not needed for the first 48 hours of inpatient Hospital services following a vaginal delivery nor the first 96 hours following a cesarean section. However, HNL should be notified within 24 hours following birth. Certification must be obtained for a scheduled cesarean section or if the Physician determines that a longer Hospital stay is Medically Necessary either prior to or following the birth.

Certification is not required for the length of a Hospital stay for reconstructive surgery incident to a mastectomy.

Certification is not needed for renal dialysis. However, HNL should be notified if renal dialysis services are received within 24 hours of the service.

Certification Procedure

Certification must be requested by You within the following periods:

- Five or more business days before the proposed admission date or the commencement of treatment, except when due to a medical emergency;
- In the event of being admitted into a Hospital or outpatient emergency room or urgent care center for Emergency Care; within 48 hours or as soon as reasonably possible; or
- Before admission to a Skilled Nursing Facility or Hospice Care program or before Home Health Care Services are scheduled to begin.

In order to obtain Certification, You or Your Physician are responsible for contacting HNL as shown on Your HNL Identification Card before receiving any service requiring Certification. If You receive any such service and do not follow the procedures set forth in this section, Your benefits may be reduced by a percentage stated in the “Schedule of Benefits” section of this *Certificate* and an additional Deductible may apply.

Verbal Certification may be given for the service. Written Certification for inpatient services will be sent to You and the provider of service.

If Certification is denied for a covered service, HNL will send a written notice to You and to the provider of the service.

Effect on Benefits

If Certification is obtained and services are rendered within the scope of the Certification, benefits for Covered Expenses will be provided in accordance with the “Medical Benefits” subsection of this *Certificate*.

If Certification is not obtained, the payable percentage will be the reduced percentage as shown in the “Schedule of Benefits” section of this *Certificate*. Also, an additional Deductible will be applied to Covered Expenses as shown in the “Schedule of Benefits” section.

Resolution of Disputes

In the event that You or Your Physician should disagree with any Certification decision made, the following dispute resolution procedure must be followed:

- Either You or Your Physician must contact HNL to request reconsideration of the decision. Additional information may be requested or the treating Physician may be consulted in any reconsideration. A written reconsideration decision will be provided; and
- If You remain dissatisfied with the reconsideration decision, please refer to the “General Provisions” section of this *Certificate* for more information.

Medical Benefits

Please read this description of plan benefits carefully. Please also read the “Schedule of Benefits” section to understand Your out-of-pocket expenses and the “General Limitations and Exclusions” section for details of any restrictions placed on the benefits.

Hospital

Inpatient Services

Covered Expenses include:

- Accommodations as an inpatient in a room of two or more beds, at the Hospital's most common semi-private room rate;
- Services in Special Care Units;
- Operating, delivery and special treatment rooms;
- Supplies and ancillary services including laboratory, cardiology, pathology, radiology and any professional component of these services;

- Physical therapy;
- Radiation therapy, chemotherapy and renal dialysis treatment;
- Drugs and medicines approved for general use by the Food and Drug Administration which are supplied by the Hospital for use during Your stay; and
- Blood transfusions, including blood processing, the cost of blood and unreplaced blood and Blood Products are covered. Self-donated (autologous) blood transfusions are covered only for a scheduled surgery that has been certified. However, this *Certificate* does not cover treatments which use umbilical cord blood, cord blood stem cells and adult stem cells (nor their collection, preservation and storage) as such treatments are considered to be Experimental or Investigational in nature. (Please refer to "Independent Medical Review of Investigational or Experimental Therapies" in the "General Provisions" section for additional information.)

Payment of benefits for hospitalizations will be reduced as set forth herein if Certification is not obtained for the hospitalization.

Outpatient Services

Covered Expenses include:

- Use of a Hospital emergency room or urgent care facility, supplies, ancillary services, laboratory and X-ray services, drugs and medicines administered by the Hospital emergency room or urgent care facility;
- Use of outpatient Hospital facility services. Examples are the use of Hospital centers in which ambulatory patients receive the following services: surgery, rehabilitation therapy (including physical, occupational and speech therapy), pulmonary rehabilitation therapy and cardiac rehabilitation therapy, laboratory tests, X-rays, radiation therapy and chemotherapy; and
- Use of the facilities of an outpatient surgical unit including operating and recovery rooms, supplies, ancillary services, laboratory and X-ray services, drugs and medicines administered by the unit.

Certification may be required. Please refer to the "Certification Requirement" portion of this *Certificate* for details. Payment of benefits for outpatient services may be reduced as set forth herein if Certification is not obtained.

Benefits will be provided for Hospital services when it is necessary to perform dental services in a Hospital, either as an inpatient or an outpatient, due to an unrelated medical condition which would threaten Your health if the dental services are not performed and when use of the Hospital setting has been ordered by both a medical doctor and a dentist. HNL shall make the final determination as to whether use of a Hospital setting was necessary.

Ambulatory Surgical Center

Outpatient diagnostic, therapeutic and surgical services and supplies for surgery performed at an Ambulatory Surgical Center.

Payment of benefits for outpatient surgery will be reduced as set forth herein if Certification is not obtained for the surgery.

Skilled Nursing Facility

You must be referred to the Skilled Nursing Facility by a Physician and must remain under the active supervision of a Physician. Your condition must be such that skilled care is Medically Necessary.

Covered Expenses include:

- Accommodations in a room of two or more beds. Payment will be made based on the Skilled Nursing Facility's prevailing charge for two-bed room accommodations;
- Special treatment rooms;
- Supplies and ancillary services including laboratory, cardiology, pathology, radiology and any professional component of these services;
- Physical, occupational and speech therapy;
- Drugs and medicines approved for general use by the Food and Drug Administration which are supplied by the Skilled Nursing Facility for use during Your stay; and

- Blood transfusions, including blood processing, the cost of blood and unreplaced blood and Blood Products are covered. Self-donated (autologous) blood transfusions are covered only for a scheduled surgery that has been certified. However, this *Certificate* does not cover treatments which use umbilical cord blood, cord blood stem cells and adult stem cells (nor their collection, preservation and storage) as such treatments are considered to be Experimental or Investigational in nature. (Please refer to “Independent Medical Review of Investigational or Experimental Therapies” in the “General Provisions” section for additional information.)

Benefits are limited to a maximum number of days per Calendar Year as set forth in the “Schedule of Benefits” section.

Payment of benefits will be reduced as set forth herein if Certification is not obtained for the confinement.

Custodial Care is not covered.

Professional Services

Necessary services of a Physician, including office visits and consultations, Hospital and Skilled Nursing Facility visits, and visits to Your home.

All covered surgical procedures, including the services of the surgeon or specialist, assistant surgeon, and anesthetist or anesthesiologist, together with preoperative and postoperative care. Surgery includes surgical reconstruction of a breast incident to a mastectomy, including surgery to restore symmetry; it also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedema.

HNL uses guidelines of Medicare and its contractors, other governmental regulatory bodies and nationally recognized medical societies and organizations to assist in its determination as to which services and procedures are eligible for reimbursement. HNL uses Medicare guidelines to determine the circumstances under which claims for assistant surgeon services and co-surgeon and team surgeon services will be eligible for reimbursement, in accordance with HNL's normal claims filing requirements.

When adjudicating claims for Covered Services for the postoperative global period for surgical procedures, HNL applies Medicare's global surgery periods to the American Medical Association defined Surgical Package. The Surgical Package includes typical postoperative care. These criteria include consideration of the time period for recovery following surgery and the need for any subsequent services or procedures which are part of routine postoperative care.

When multiple procedures are performed at the same time, Covered Expenses include the Contracted Rate or Maximum Allowable Amount (as applicable) for the first (or major) procedure and one-half the Contracted Rate or Maximum Allowable Amount for each additional procedure. HNL uses Medicare guidelines to determine the circumstances under which claims for multiple surgeries will be eligible for reimbursement, in accordance with HNL's normal claims filing requirements. No benefit is payable for incidental surgical procedures, such as an appendectomy performed during gall bladder surgery.

HNL uses Medicare guidelines to determine which services and procedures are eligible for payment separately or as part of a bundled package, including but not limited to, which items are separate professional or technical components of services and procedures.

Payment of benefits for surgical expenses will be reduced as set forth in this *Certificate* if Certification is not obtained for the surgery.

Diagnostic Imaging (Including X-Ray) and Laboratory Procedures

All prescribed diagnostic imaging (including x-ray) and laboratory procedures, services and materials, including cancer screening tests.

Home Health Care Services

The services of a Home Health Care Agency in the Covered Person's home are covered when provided by a registered nurse or licensed vocational nurse and /or licensed physical, occupational, speech therapist or respiratory therapist. These services are in the form of visits that may include, but are not limited to, skilled nursing services, medical social services, rehabilitation therapy (including physical, speech and occupational), pulmonary rehabilitation therapy and cardiac rehabilitation therapy.

Home Health Care Services must be ordered by Your Physician, approved by HNL and provided under a treatment plan describing the length, type and frequency of the visits to be provided. The following conditions must be met in order to receive Home Health Care Services:

- The skilled nursing care is appropriate for the medical treatment of a condition, illness, disease or injury;
- The Covered Person is homebound because of illness or injury (this means that the Covered Person is normally unable to leave home unassisted, and, when the Covered Person does leave home, it must be to obtain medical care, or for short, infrequent non-medical reasons such as a trip to get a haircut, or to attend religious services or adult day care);
- The Home Health Care Services are part-time and intermittent in nature; a visit lasts up to 4 hours in duration in every 24 hours; and
- The services are in place of a continued hospitalization, confinement in a Skilled Nursing Facility, or outpatient services provided outside of the Covered Person home.

Custodial Care services and Private Duty Nursing, as described in the “Definitions” section and any other types of services primarily for the comfort or convenience of the Covered Person, are not covered even if they are available through a Home Health Care Agency. Home Health Care Services do not include Private Duty Nursing or shift care. Private Duty Nursing (or shift care, including any portion of shift care services) is not a covered benefit under this plan even if it is available through a Home Health Care Agency or is determined to be Medically Necessary. See the “Definitions” section.

The maximum number of covered visits per Calendar Year is set forth in the “Schedule of Benefits” section.

In addition, in accordance with an approved treatment plan, coverage will be provided for therapies in the home, when determined medically appropriate as an alternative to inpatient care, upon prior written approval by HNL. All home health services and supplies directly related to infusion therapy are payable as stated in the “Outpatient Infusion Therapy” provision below, and are not payable under this Home Health Care Services benefit.

Payment of benefits will be reduced as set forth herein if Certification is not obtained.

Self-Injectable Drugs

Self-injectable drugs are covered when prescribed by a Physician and dispensed by a licensed pharmacy.

These drugs are not covered under any outpatient Prescription Drug program which may be described within this *Certificate*, but are covered only as described within this “Plan Benefits” section. (Note that insulin is only covered through an outpatient Prescription Drug program.)

When a self-injectable drug is prescribed, You have the option of having Your prescription filled through HNL’s contracted Specialty Pharmacy Vendor. However, needles and syringes required to administer the self-injected medications are covered only when obtained through the Specialty Pharmacy Vendor. If You have met Your Calendar Year Deductible (if applicable), the Specialty Pharmacy Vendor will only charge You for the appropriate Copayment or Coinsurance shown in the “Schedule of Benefits” section. HNL will reimburse the Specialty Pharmacy Vendor directly. The Specialty Pharmacy Vendor may contact You directly to coordinate the delivery of Your medications.

If You do not fill Your prescription through the Specialty Pharmacy vendor, You must pay the full cost of the prescription to the pharmacist at the time the drug is dispensed. Then You must file a claim for reimbursement. HNL will first subtract any charges billed in excess of the Covered Expense. Then HNL will subtract the applicable Deductible(s), and the Copayment or Coinsurance shown for Preferred Providers or Out-of-Network Providers (as applicable, depending on the provider who wrote the prescription) in the “Schedule of Benefits” section. You will be reimbursed for the remainder.

Outpatient Infusion Therapy

Outpatient infusion therapy used to administer covered drugs and other substances by injection or aerosol is covered when appropriate for Your illness, injury or condition and will be covered for the number of days necessary to treat the illness, injury or condition.

Infusion therapy includes: total parenteral nutrition (TPN) (nutrition delivered through the vein); injected or intravenous antibiotic therapy; chemotherapy; injected or intravenous Pain management; intravenous hydration

(substances given through the vein to maintain the patient's fluid and electrolyte balance, or to provide access to the vein); aerosol therapy (delivery of drugs or other Medically Necessary substances through an aerosol mist); and tocolytic therapy to stop premature labor.

Covered services include professional services (including clinical pharmaceutical support) to order, prepare, compound, dispense, deliver, administer or monitor covered drugs or other covered substances used in infusion therapy.

Covered supplies include injectable Prescription Drugs or other substances which are approved by the California Department of Health or the Food and Drug Administration for general use by the public. Other Medically Necessary supplies and Durable Medical Equipment necessary for infusion of covered drugs or substances are covered.

All services must be billed and performed by a provider licensed by the state. Only a 14-day supply will be dispensed per delivery.

Infusion therapy benefits will not be covered in connection with the following:

- Non-Prescription Drugs or medications;
- Any drug labeled "Caution, limited by Federal Law to Investigational use" or Investigational drugs not approved by the FDA;
- Drugs or other substances obtained outside of the United States;
- Homeopathic or other herbal medications not approved by the FDA;
- FDA approved drugs or medications prescribed for indications that are not approved by the FDA, or which do not meet medical community standards (except for non-Investigational FDA approved drugs used for off-label indications when the conditions of state law have been met);
- Growth hormone treatment; or
- Supplies used by a health care provider that are incidental to the administration of infusion therapy, including but not limited to: cotton swabs, bandages, tubing, syringes, medications and solutions.

Payment of benefits will be reduced as set forth herein if Certification is not obtained for the therapy.

Ambulance Services

The following Ambulance services:

- **Ground Ambulance Transportation**, when it is Medically Necessary, as defined in the "Definitions" section. The following will be covered:

Charges for the base rate, mileage (up to the maximum number of miles stated in the "Schedule of Benefits" section), disposable supplies (supplies which can be used again are not covered), monitoring, electrocardiograms (EKGs), cardiac defibrillation, cardiopulmonary resuscitation (CPR), and administration of oxygen and intravenous (IV) solutions in connection with Ambulance services when the transportation involves:

1. A trip to a Hospital or Skilled Nursing Facility where You receive care which is covered under this *Certificate* as an inpatient, in the emergency room or in the outpatient department of a Hospital when the services could not have been performed in the home;
2. A round trip from a Hospital or Skilled Nursing Facility where covered care is being provided, to some other medical treatment facility in order to obtain specialized diagnostic or therapeutic services (for example, a CT scan or radiation therapy) which are not available at the facility where You are an inpatient. The other medical treatment facility can be a Hospital, Skilled Nursing Facility, clinic, therapy center, diagnostic center or Physician's office; or
3. A trip to Your home from a Hospital or Skilled Nursing Facility where You received covered services.

- **Air Ambulance Transportation**, when it is Medically Necessary, as defined in the “Definitions” section. The following will be covered:

Charges for the base rate, mileage, disposable supplies, monitoring, electrocardiograms (EKGs), cardiac defibrillation, cardiopulmonary resuscitation (CPR), and administration of oxygen and intravenous (IV) solutions in connection with air Ambulance services when the transportation is from any location to a Hospital or a location nearby, such as an airport, for admission as an inpatient or treatment in an emergency room, and the Hospital services are themselves covered under this *Certificate*.

Payment of benefits for Air Ambulance Services will be reduced as set forth herein if Certification is not obtained.

All paramedic, Ambulance and Ambulance transport services provided as a result of a “911” emergency response system call will be covered when the criteria for Emergency Care, as defined in this *Certificate*, have been met.

Acupuncture

Medically Necessary acupuncture services, subject to the benefit maximums shown in the “Schedule of Benefits” section.

Diabetes Education

HNL will pay for a diabetes instruction program supervised by a Physician. A diabetes instruction program is a program designed to teach You (the diabetic) and Your covered Dependents about the disease process and the daily management of diabetic therapy.

Hospice Care

Hospice Care is care that is reasonable and necessary to control or manage terminal illness or related conditions. Hospice Care benefits are designed to be provided primarily in Your home. To be considered terminally ill, a Covered Person must have been given a medical prognosis of one year or less to live.

If You receive Hospice Care benefits You are entitled to the following:

- All Medically Necessary services and supplies furnished by the Hospice. This includes doctors' and nurses' services, homemaker services and drugs;
- Up to five consecutive days of respite care. Respite care is furnished to a person in an inpatient setting in order to provide relief for family members or others caring for that person; and
- All of these services and supplies will be provided or arranged by the Hospice. Payment by HNL for Hospice Care benefits shall not exceed the amount per day set forth in the “Schedule of Benefits” section.

Payment of benefits will be reduced as set forth herein if Certification is not obtained for the care.

Radiation Therapy, Chemotherapy and Renal Dialysis Treatment

Radiation therapy and nuclear medicine, chemotherapy and renal dialysis treatment are covered when determined to be Medically Necessary.

Bariatric (Weight Loss) Surgery

Bariatric surgery provided for the treatment of morbid obesity is covered when Medically Necessary authorized by HNL and performed at a Bariatric Surgery Performance Center by an HNL Bariatric Surgery Performance Center network surgeon who is affiliated with the HNL Bariatric Surgery Performance Center. Preferred Providers that are not designated as part of HNL's network of Bariatric Surgery Performance Centers are considered Out-of-Network Providers for purposes of determining coverage and benefits for weight loss surgery.

Bariatric Surgery Performance Centers are HNL's designated network of bariatric surgical centers and surgeons to perform weight loss surgery. Your Physician can provide You with information about this network. You will be directed to an HNL Bariatric Surgery Performance Center at the time authorization is obtained.

If You live 50 miles or more from the nearest HNL designated bariatric surgical center, You are eligible to receive travel expense reimbursement. All requests for travel expense reimbursement must be prior approved by HNL. Approved travel-related expenses will be reimbursed as follows:

- Transportation for the Covered Person to and from the Bariatric Surgery Performance Center up to \$130 per trip for a maximum of three (3) trips (one pre-surgical visit, the initial surgery and one follow-up visit).
- Transportation for one companion (whether or not an enrolled Covered Person) to and from the Bariatric Surgery Performance Center up to \$130 per trip for a maximum of two (2) trips (the initial surgery and one follow-up visit).
- Hotel accommodations for the Covered Person and one companion not to exceed \$100 per day for the pre-surgical visit and the follow-up visit, up to two (2) days per trip or as Medically Necessary. Limited to one room, double occupancy.
- Hotel accommodations for one companion not to exceed \$100 per day for the duration of the Covered Person's initial surgery stay, up to four (4) days. Limited to one room, double occupancy.
- Other reasonable expenses not to exceed \$25 per day, up to four (4) days per trip. Expenses for tobacco, alcohol, drugs, telephone, television, delivery, and recreation are specifically excluded.

Submission of adequate documentation including receipts is required to receive travel expense reimbursement from HNL.

Prostheses

Prostheses are covered as follows:

- Internally implanted devices, such as pacemakers, devices to restore speaking after a laryngectomy and hip joints, which are medically indicated and consistent with accepted medical practice and approved for general use by the Federal Food and Drug Administration;
- External prostheses and the fitting and adjustment of these devices; and
- Visual aids (excluding eyewear) to assist the visually impaired with proper dosing of insulin.

For the purpose of this section, external prostheses are those which are:

- Required to replace all or any part of any body organ or extremity; or
- Affixed to the body externally.

In the event that more than one type of prosthesis is available, benefits will be provided only for the device or appliance which is medically and reasonably indicated in accordance with accepted medical practice.

In addition, the following prostheses are covered, but not subject to the benefit maximum shown in the "Schedule of Benefits" section:

- If all or part of a breast is surgically removed for Medically Necessary reasons, reconstructive surgery and a prosthesis incident to the mastectomy are covered; and
- Prostheses for restoring a method of speaking (but not including electronic voice boxes) following a laryngectomy are covered.

Repair or replacement of prostheses is covered unless necessitated by misuse or loss. HNL may, at its option, pay for replacement rather than the repair of an item. Expenses for replacement are covered only when a prosthesis is no longer functional.

Certification may be required. Please refer to the "Certification Requirement" portion of this section for details. Payment of benefits will be reduced as set forth herein if Certification is required but not obtained.

Medically Necessary Corrective Footwear

Corrective footwear and foot orthotic devices, which are used to protect the foot or to overcome abnormal foot conditions, are covered when Medically Necessary and custom made for the Covered Person, even for conditions not related to diabetes. Corrective footwear and foot orthotic devices for the management and treatment of diabetes are covered as described under the "Diabetic Equipment" provision of this section. HNL applies nationally recognized Durable Medical Equipment coverage guidelines as defined by the Medicare Durable Medical Equipment Regional Administrative Contracts (DME MAC), HCPCS Level II and Medicare National Coverage Determinations (NCD) in assessing Medical Necessity for coverage.

Rental or Purchase of Durable Medical Equipment

Rental or purchase of Durable Medical Equipment which is ordered or prescribed by a Physician and is manufactured primarily for medical use. Durable Medical Equipment which is used for infusion therapy, corrective shoes or shoe inserts will be payable only as stated in the "Outpatient Infusion Therapy" or "Medically Necessary Corrective Footwear" provisions above. Durable Medical Equipment includes, but is not limited to, wheelchairs, crutches, bracing, supports, casts and Hospital beds. HNL applies nationally recognized Durable Medical Equipment coverage guidelines as defined by the Medicare Durable Medical Equipment Regional Administrative Contracts (DME MAC), HCPCS Level II and Medicare National Coverage Determinations (NCD) in assessing Medical Necessity for coverage. Some Durable Medical Equipment may have specific quantity limits or may not be covered if they are considered primarily for non-medical use. Orthotics are not subject to such quantity limits.

Certification may be required. Please refer to the "Certification Requirement" portion of this section for details. Payment of benefits will be reduced as set forth herein if Certification is required but not obtained.

Implanted Lens(es) Which Replace the Organic Eye Lens

Implanted lens(es) which replace the organic eye lens are covered when Medically Necessary.

Rehabilitative Services

Rehabilitative services (including physical, occupational and speech therapy,) when Medically Necessary and continuous functional improvement in response to the treatment plan is demonstrated by objective evidence, in accordance with the "Schedule of Benefits" section, except as stated in the "General Limitations and Exclusions" section.

Cardiac Rehabilitation Therapy

Cardiac rehabilitation therapy, when Medically Necessary and continuous functional improvement in response to the treatment plan is demonstrated by objective evidence, in accordance with the "Schedule of Benefits" section, except as stated in the "General Limitations and Exclusions" section.

Pulmonary Rehabilitation Therapy

Pulmonary rehabilitation therapy, when Medically Necessary and continuous functional improvement in response to the treatment plan is demonstrated by objective evidence, in accordance with the "Schedule of Benefits" section, except as stated in the "General Limitations and Exclusions" section.

Allergy Testing and Treatment

The testing and treatment of allergies is covered. This includes allergy serum.

Reconstructive Surgery

Reconstructive surgery to restore and achieve symmetry including surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or create a normal appearance to the extent possible, unless the surgery offers only a minimal improvement in Your appearance. This includes reconstructive surgery to restore and achieve symmetry incident to mastectomy and Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate. This does not include cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve appearance or dental services or supplies or treatment for disorders of the jaw except as set out under the "Dental Services" and "Temporomandibular (Jaw) Joint Disorders" portions of the "General Limitations and Exclusions" section.

*The coverage described above in relation to a Medically Necessary mastectomy complies with requirements under the **Women's Health and Cancer Rights Act of 1998**. In compliance with the Women's Health Cancer Rights Act of 1998, this Plan provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. See also "Prostheses" in this "Covered Services and Supplies" section for a description of coverage for prostheses.*

Diabetic Equipment

Equipment and supplies for the management and treatment of diabetes are covered, as Medically Necessary, including:

- Insulin pumps and all related necessary supplies
- Corrective footwear to prevent or treat diabetes-related complications
- Specific brands of blood glucose monitors and blood glucose testing strips*
- Blood glucose monitors designed to assist the visually impaired
- Ketone urine testing strips*
- Lancets and lancet puncture devices*
- Specific brands of pen delivery systems for the administration of insulin, including pen needles*
- Specific brands of disposable insulin needles and syringes*

* These items (as well as insulin and Prescription Drugs for the treatment and management of diabetes) are covered under the Prescription Drug benefits. Please refer to the "Outpatient Prescription Drug Benefits" portion of this section for additional information.

Additionally, the following supplies are covered under the medical benefit as specified:

- Visual aids (excluding eyewear) to assist the visually impaired with proper dosing of insulin are provided through the prostheses benefit (see the "Prostheses" provision of this section).
- Glucagon is provided through the self-injectables benefit (see the "Self-Injectable Drugs" provision of this section).
- Self-management training, education and medical nutrition therapy will be covered, only when provided by licensed health care professionals with expertise in the management or treatment of diabetes. Please refer to the "Diabetes Education" provision of this section for more information.

Preventive Care For Adults

Preventive care and diagnostic procedures for adults (age 17 and older) are covered at a Physician's direction when Medically Necessary and consistent with good professional practice. Covered services are limited to the following types of care and procedures:

- **Annual Preventive Physical Exam:** For preventive health purposes, a periodic health evaluation including diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force.
- **Mammography:** One mammogram every Calendar Year for women.
- **Cervical Cancer Screening Test:** One cervical cancer screening test per Calendar Year for women (includes the conventional Pap test, a human papillomavirus (HPV) screening test that is approved by the Food and Drug Administration (FDA) and the option of any cervical cancer screening test approved by the FDA).
- **Pelvic Exam and Breast Exam:** One normal exam and lab test per Calendar Year for women.
- **Digital Rectal Exam and Fecal Occult Blood Test:** Once every Calendar Year for men and women. Additional screening services for colorectal cancer, including but not limited to colonoscopy, may be covered under Hospital Services. Refer to the "Plan Benefits" section for additional details.
- **Screening and Diagnosis of Prostate Cancer:** Tests and procedures for the screening and diagnosis of prostate cancer, including but not limited to, prostate-specific antigen testing and digital rectal examinations.

Preventive Care For Children

Preventive care and diagnostic procedures (including newborn pediatric care) for children through age 16, are covered and are limited to the following type of care or procedures:

- Office visits for the evaluation and management of the child's physical development for prevention of future medical problems;
- Vision and hearing exams
- Laboratory tests and x-rays; and
- Immunizations.

The above shall be consistent with the Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics (AAP) and the Recommended Childhood Immunization Schedule/United States jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices (ACIP) of the U.S. Public Health Service and the American Academy of Family Physicians.

Phenylketonuria (PKU)

Coverage for testing and treatment of phenylketonuria (PKU) includes formulas and special food products that are part of a diet prescribed by a Physician and managed by a licensed health care professional in consultation with a Physician who specializes in the treatment of metabolic disease. The diet must be deemed Medically Necessary to prevent the development of serious physical or mental disabilities or to promote normal development or function. Coverage is provided only for those costs which exceed the cost of a normal diet.

"Formula" is an enteral product for use at home that is prescribed by a Physician.

"Special food product" is a food product that is prescribed by a Physician for treatment of PKU and used in place of normal food products, such as grocery store foods. It does not include a food that is naturally low in protein.

Other specialized formulas and nutritional supplements are not covered.

Osteoporosis

Services related to the diagnosis, treatment and appropriate management of osteoporosis. Covered services may include, but are not limited to, all FDA-approved technologies, including bone mass measurement technologies as deemed medically appropriate.

Immunizations for adults

Immunizations for adults are covered (except for immunizations for foreign travel or occupational purposes).

The above shall be consistent with the Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics (AAP) and the Recommended Childhood Immunization Schedule/United States jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices (ACIP) of the U.S. Public Health Service and the American Academy of Family Physicians.

Surgically Implanted Drugs

Surgically implanted drugs are covered under the medical benefit when Medically Necessary, and may be provided in an inpatient or outpatient setting.

Dental Injury

Emergency Care of a Physician, while You are covered under this *Certificate*, treating an Accidental Injury to the natural teeth. You must be covered under this *Certificate* at the time such services are rendered. Medically Necessary related Emergency Hospital services will also be covered. Damage to natural teeth due to chewing or biting is not Accidental Injury. Dental appliances are not a Covered Expense.

Care for Conditions of Pregnancy

Hospital and professional services will be covered, including prenatal and postnatal care, and delivery. Covered Expenses include prenatal diagnostic procedures in the case of high-risk pregnancies.

Terminations of pregnancy (surgical or drug) are covered whether they are Medically Necessary or elective.

Organ, Tissue and Bone Marrow Transplants

Organ donation extends and enhances lives and is an option that You may want to consider. For more information on organ donation, including how to elect to be an organ donor, please contact the Member Services Department at the telephone number on Your HNL ID Card, or visit the Department of Health and Human Services organ donation website at www.organdonor.gov.

If You receive services which are not certified by HNL for an organ, tissue or stem cell transplant, You will incur the noncertification penalties described in the "Schedule of Benefits" section.

- Transplant travel expenses (benefit limitations):

For transplant recipient and one companion per transplant episode (limited to 6 trips per episode)

1. Transportation to transplant center: \$250 per trip for each person (round-trip coach airfare)
2. Hotel accommodations: \$100 per day, for up to 21 days per trip, limited to one room (double occupancy)
3. Meals & miscellaneous expenses: \$25 per day for each person, for up to 21 days per trip

For the donor per transplant episode (limited to one trip per episode)

1. Transportation to transplant center: \$250 for round-trip coach airfare
2. Hotel accommodations: \$100 per day, for up to 7 days
3. Meals & miscellaneous expenses: \$25 per day, up to 7 days

Organ, tissue and stem cell transplants are not covered if provided by an Out-of-Network Provider.

Family Planning

Services in relation to conception by artificial means are not covered. (See the "Conception by Medical Procedures" provision in the "General Limitations and Exclusions" section for more information.)

Clinical Trials

Routine patient care costs for patients diagnosed with cancer who are accepted into phase I, II, III or IV clinical trials are covered when Medically Necessary, recommended by the Covered Person's treating Physician and authorized by HNL. The Physician must determine that participation has a meaningful potential to benefit the Covered Person and the trial has therapeutic intent. Clinical trial services performed by Out-of-Network Providers are covered only when the protocol for the trial is not available through Preferred Providers. Services rendered as part of a clinical trial subject to the reimbursement guidelines as specified in the law. The treatment shall be provided in a clinical trial that involves either a drug that is exempt from federal regulation in relation to a new drug application, or is approved by one of the following:

- The National Institutes of Health;
- The FDA as an Investigational new drug application;
- The Department of Defense; or
- The Veterans' Administration.

The following definition applies to the terms mentioned in the above provision only.

"Routine patient care costs" are the costs associated with the standard provisions of HNL, including drugs, items, devices and services that would normally be covered under this *Certificate*, if they were not provided in connection with a clinical trials program.

Please refer to the "Medical Services and Supplies" portion of the "General Limitations and Exclusions" section for more information.

Chiropractic Services

Chiropractic services are covered in accordance with the "Schedule of Benefits" section, when the services are provided by a Contracted Chiropractor located in the State of California.

An initial examination is covered to determine the nature of Your problem. Subsequent visits are covered up to the maximum number of visits stated in the "Schedule of Benefits" section, when determined to be Medically Necessary for the treatment of a Neuro-Musculoskeletal Disorder, as described in the proposed Chiropractic Treatment Plan.

Covered services received during a subsequent visit may include manipulations, adjustments, therapy, x-ray procedures and laboratory tests in various combinations.

X-ray services are also covered under this benefit when prescribed by a Contracted Chiropractor and performed by another party.

X-ray second opinions, however, will be a covered benefit only when performed by a licensed radiologist for verification of suspected tumors or fractures, not for routine care.

The following services or supplies are not covered under this benefit:

- Examinations or treatments for conditions other than those related to Neuro-Musculoskeletal Disorders, and physical therapy not associated with spinal, muscle or joint manipulation
- Laboratory services
- Surgical procedures
- Durable Medical Equipment, drugs or medications (prescription or non-prescription)
- Hypnotherapy, behavior training, sleep therapy and weight programs
- Massage therapy
- Thermography
- Magnetic Resonance Imaging and any types of diagnostic radiology, other than x-rays
- Transportation costs including local Ambulance charges
- Education programs, non-medical self-care, self-help training or any related diagnostic testing
- Vitamins, minerals, nutritional supplements or other similar products

Mental Health Care and Chemical Dependency Benefits

Certain limitations or exclusions may apply. Please read the "General Exclusions and Limitations" section of this Certificate.

Payment of benefits for Mental Disorders and Chemical Dependency services will be reduced as set forth herein if Certification is required but not obtained for the services.

The following benefits are provided:

Serious Emotional Disturbances of a Child - The treatment and diagnosis of Serious Emotional Disturbances of a Child under the age of 18 is covered as shown in the "Schedule of Benefits" section.

Severe Mental Illness - Treatment of Severe Mental Illness is covered as shown in the "Schedule of Benefits" section.

Covered services include treatment of:

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (manic-depressive illness)
- Major depressive disorders
- Panic disorder
- Obsessive-compulsive disorder

- Pervasive developmental disorder (including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified to include Atypical Autism, in accordance with the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders)
- Autism
- Anorexia nervosa
- Bulimia nervosa

Outpatient Services - Outpatient services are covered as shown in the "Schedule of Benefits" section under "Mental Disorders and Chemical Dependency Benefits."

Covered services include:

- Outpatient crisis intervention, short-term evaluation and therapy, longer-term specialized therapy and rehabilitative care that is related to Chemical Dependency
- Medication management care, when appropriate.
- Intensive outpatient care program which is a treatment program that is utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three (3) hours per day, three (3) times per week.
- Partial hospitalization/day treatment program which is a treatment program that may be free-standing or Hospital-based and provides services at least four (4) hours per day and at least four (4) days per week.

Inpatient Services - Inpatient services are covered as shown in the "Schedule of Benefits" section under "Mental Disorders and Chemical Dependency Benefits."

Covered services and supplies include:

- Accommodations in a room of two or more beds, including special treatment units, such as intensive care units and psychiatric care units, unless a private room is determined to be Medically Necessary.
- Supplies and ancillary services normally provided by the facility, including professional services, laboratory services, drugs and medications dispensed for use during the confinement, psychological testing and individual, family or group therapy or counseling.
- Medically Necessary services in a Residential Treatment Center are covered except as stated in the "General Exclusions and Limitations" section.

Detoxification - Inpatient services for acute detoxification and treatment of acute medical conditions relating to Chemical Dependency are covered.

Outpatient Prescription Drug Benefits

The preceding sections of this *Certificate* provide coverage for Prescription Drugs obtained while an inpatient in a Hospital or Skilled Nursing Facility. This plan also includes coverage for Prescription Drugs outside a Hospital or Skilled Nursing Facility setting. This outpatient Prescription Drug benefit is subject to a specific set of terms and conditions documented in this *Certificate* which You must be informed about in order to obtain the highest level of coverage under this benefit. The provisions which follow are in addition to, and do not replace, any other provision under this *Certificate* which may apply to Prescription Drugs.

Covered Drugs and Supplies

Outpatient Prescription Drug Benefits shall be provided if You, while covered under this *Certificate*, incur an expense for Prescription Drugs which were prescribed by any Physician who is either a Preferred Provider or Out-of-Network Provider. You are responsible for the applicable Deductible, Copayment or Coinsurance, as shown in the "Schedule of Benefits" section of this *Certificate*.

Prescription Drugs must be dispensed for a condition, illness or injury that is covered by this Plan. Refer to the "General Limitations and Exclusions" section of this *Certificate* to find out if a particular condition is not covered.

Level I Drugs (Primarily Generic) and Level II Drugs (Primarily Brand)

Prescription Drugs listed in the Health Net Recommended Drug List are covered, when prescribed by a Physician, an authorized referral specialist or an emergent or urgent care Physician. Some Level I and Level II Drugs require Prior Authorization from HNL to be covered. The fact that a drug is listed in the Recommended Drug List does not guarantee that Your Physician will prescribe it for You for a particular medical condition.

Level III Drugs

Level III Drugs are Prescription Drugs that may be Generic Drugs or Brand Name Drugs, and are either:

- Specifically listed as Level III on the Recommended Drug List; or
- Not listed in the Health Net Recommended Drug List that are not excluded or limited from coverage.

Some Level III Drugs require Prior Authorization from HNL to be covered.

Please refer to the "Recommended Drug List" portion of this subsection for more details.

Compounded Drugs

Prescription Drug Orders that are combined or manufactured by the pharmacist and placed in ointment, capsule, tablet, solution, suppository, cream or other form using FDA approved drugs, are covered at the Level III Drug Copayment. Coverage for Compounded Drugs is subject to Prior Authorization by HNL and Medical Necessity. Compounded Drugs are not covered if there is a similar proprietary product available.

Generic Equivalents to Brand Name Drugs

You are financially responsible for the applicable Deductible, Copayment or Coinsurance for the Brand Name Drug plus an additional amount, as shown in the "Schedule of Benefits" section of this *Certificate*, if a Generic Drug equivalent is commercially available, but You:

- Receive a Brand Name Drug at a Participating Pharmacy or through the Mail Order Program; or
- Submit a claim for a Brand Name Drug from a Nonparticipating Pharmacy or due to Emergency Care.

However, if the Prescription Drug Order states "do not substitute" or "dispense as written" or words of similar meaning in the Physician's handwriting, You are only responsible for the applicable Deductible and Copayment.

Off-Label Drugs

A Prescription Drug prescribed for a use that is not stated in the indications and usage information published by the manufacturer is covered only if the drug meets all of the following coverage criteria:

1. The drug is approved by the Food and Drug Administration; AND
2. The drug meets one of the following conditions:
 - A. The drug is prescribed by a participating licensed health care professional for the treatment of a life-threatening condition; OR
 - B. The drug is prescribed by a participating licensed health care professional for the treatment of a chronic and seriously debilitating condition, the drug is Medically Necessary to treat such condition and the drug is either on the Recommended Drug List or Prior Authorization by HNL has been obtained; AND
3. The drug is recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following:
 - A. The American Hospital Formulary Service Drug Information; OR
 - B. One of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer therapeutic regimen:
 - i. The Elsevier Gold Standard's Clinical Pharmacology.
 - ii. The National Comprehensive Cancer Network Drug and Biologics Compendium.
 - iii. The Thomson Micromedex DrugDex; OR
 - C. Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

The following definitions apply to the terms mentioned in this provision only.

“Life-threatening” means either or both of the following:

- A. Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted;
- B. Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

“Chronic and seriously debilitating” refers to diseases or conditions that require ongoing treatment to maintain remission or prevent deterioration and cause significant long-term morbidity.

Diabetic Drugs and Supplies

Prescription Drugs for the treatment of diabetes (including insulin) are covered as stated in the Recommended Drug List. Diabetic supplies are also covered, including, but not limited to, specific brands of pen delivery systems, specific brands of disposable insulin needles and syringes, disposable insulin pen needles, specific brands of blood glucose monitors and test strips (specific brands only); Ketone test strips; lancet puncture devices and lancets when used in monitoring blood glucose levels. Additional supplies are covered under the medical benefit; please refer to the “Diabetic Equipment” provision of the “Medical Benefits” portion of this section; please refer to the “Schedule of Benefits” section for details about the supply amounts that are covered at the applicable Copayment.

Sexual Dysfunction Drugs

Drugs that establish, maintain or enhance sexual functioning are covered for sexual dysfunction when Medically Necessary. Sexual Dysfunction Drugs are covered when Prior Authorization is obtained from HNL. Injectable sexual dysfunction drugs must be dispensed through HNL’s Specialty Pharmacy Vendor. These Prescription Drugs are covered for up to the number of doses or tablets specified in HNL’s Recommended Drug List. For information about HNL’s Recommended Drug List, please call the Member Services Department at the telephone number on Your ID card.

Contraceptives

Vaginal, oral and emergency contraceptives are covered. Vaginal contraceptives include diaphragms and cervical caps, when a Physician performs a fitting examination and prescribes the device. Such devices are only available through a prescription from a pharmacy and limited to one fitting and prescription per Calendar Year unless additional fittings or devices are Medically Necessary. For a complete list of contraceptive products covered by HNL, please refer to the Recommended Drug List. Injectable contraceptives are covered as a medical benefit when administered by a Physician.

The Recommended Drug List

What is the Health Net Recommended Drug List?

HNL developed the Recommended Drug List to identify the safest and most effective medications for Health Net Life Covered Persons while attempting to maintain affordable pharmacy benefits. We specifically suggest to all Preferred Providers that they refer to this List when choosing drugs for patients who are Health Net Life Covered Persons. When Your Physician prescribes medications listed in the Recommended Drug List, it is ensured that You are receiving a high quality and high value prescription medication. In addition, the Recommended Drug List identifies whether a Generic version of a Brand Name Drug exists, and whether the drug requires Prior Authorization. If the Generic version exists, it will be dispensed instead of the Brand Name version.

You may call the Member Services Department at the telephone number on Your HNL ID Card to find out if a particular drug is listed in the Recommended Drug List. You may also request a copy of the current List, and it will be mailed to You. The current List is also available on the HNL website at www.healthnet.com under the pharmacy information.

How are Drugs Chosen for the Health Net Recommended Drug List?

The List is created and maintained by the Health Net Pharmacy and Therapeutics Committee. Before deciding whether to include a drug on the List, the Committee reviews medical and scientific publications, relevant utilization experience and Physician recommendations to assess the drug for its:

- Safety
- Effectiveness

- Cost-effectiveness (when there is a choice between two drugs having the same effect, the less costly drug will be listed)
- Side effect profile
- Therapeutic outcome

This Committee has quarterly meetings to review medications and to establish policies and procedures for drugs included in the List. The Recommended Drug List is updated as new clinical information and medications are approved by the FDA.

Who is on the Health Net Pharmacy and Therapeutics Committee and How are Decisions Made?

The Committee is made up of actively practicing Physicians of various medical specialties from Health Net contracting Physician groups, as well as clinical pharmacists. Voting members are recruited from contracting Physician groups throughout California based on their experience, knowledge and expertise. In addition, the Pharmacy and Therapeutics Committee frequently consults with other medical experts to provide additional input to the Committee. A vote is taken before a drug is added to the Recommended Drug List. The voting members are not employees of HNL. This ensures that decisions are unbiased and without conflict of interest.

Prior Authorization Process

Prior Authorization status is included in the Recommended Drug List. The List identifies which drugs require Prior Authorization. A Physician must get approval from HNL before writing a Prescription Drug Order for a drug that is listed as requiring Prior Authorization, in order for the drug to be covered by HNL. If a drug is not on the List, Your Physician should call HNL to determine if the drug requires Prior Authorization.

Urgent requests from Physicians are handled in a timely fashion, not to exceed 72 hours, as appropriate and Medically Necessary, for the nature of the Covered Person's condition hours after HNL's receipt of the information reasonably necessary and requested by HNL to make the determination. Routine requests from Physicians are processed in a timely fashion, not to exceed five days, as appropriate and Medically Necessary for the nature of the Covered Person's condition after HNL's receipt of the information reasonably necessary and requested by HNL to make the determination. Requests may be submitted by telephone or facsimile. HNL will evaluate the submitted information upon receiving Your Physician's request for Prior Authorization and make a determination based on established clinical criteria for the particular medication. The criteria used for Prior Authorization are developed and based on input from the Health Net Pharmacy and Therapeutics Committee as well as Physician experts. Your Physician may contact HNL to obtain the usage guidelines for specific medications.

Retail Pharmacies and the Mail Order Program

Prescription Drugs Dispensed by a Participating Pharmacy

You must purchase covered drugs at a Participating Pharmacy to receive the highest available benefits for Prescription Drugs under this Plan.

HNL is contracted with many major pharmacy chains, supermarket based pharmacies and privately owned neighborhood pharmacies in California.

To find a conveniently located Participating Pharmacy, please visit Our website at www.healthnet.com or call the Member Services Department at the telephone number on Your HNL ID Card. Present the HNL ID Card and pay the appropriate Copayment when the drug is dispensed.

If refills are stipulated on the Prescription Drug Order, a Participating Pharmacy may dispense up to a 30-consecutive-calendar-day supply for each Prescription Drug Order or for each refill at the appropriate time interval.

In some cases, a 30-consecutive-calendar-day supply of medication may not be an appropriate drug treatment plan according to the Food and Drug Administration (FDA) or HNL's usage recommendation. If this is the case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply.

(If the Health Net PPO identification card has not been received or if it has been lost, refer to the provision below, "When the Health Net PPO Identification Card is not in Your Possession.")

Preferred Providers and Participating Pharmacies prescribe and dispense Prescription Drugs listed in the Recommended Drug List.

Specialty Drugs Dispensed by the Specialty Pharmacy Vendor

Specialty Drugs must be obtained through the Specialty Pharmacy Vendor. Once the Prior Authorization request has been approved by HNL, HNL will forward the prescription order to the Specialty Pharmacy Vendor. The Specialty Pharmacy Vendor may contact You directly to coordinate the delivery of Your medications.

The Specialty Pharmacy Vendor may dispense up to a 30-consecutive-calendar-day supply for each Prescription Drug Order or for each refill at the appropriate time interval. In some cases, a 30-consecutive-calendar-day supply of medication may not be an appropriate drug treatment plan according to the Food and Drug Administration (FDA) or HNL's usage recommendation. If this is the case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply.

Prescription Drugs Dispensed by a Nonparticipating Pharmacy

The maximum charge HNL will allow for a Prescription Drug Order is the Prescription Drug Covered Expense, as defined in the "Definitions" section. It is not necessarily the amount a Nonparticipating Pharmacy will charge. You are financially responsible for any amount charged by a Nonparticipating Pharmacy which exceeds the amount of Prescription Drug Covered Expense in addition to the appropriate Copayment or Coinsurance. If You present a Prescription Drug Order for a Brand Name Drug, pharmacists will offer a Generic Drug equivalent if commercially available. At the time of the Emergency or Urgent Care visit, You should advise the treating Physician of any drug allergies or reactions, including to any Generic Drugs.

When Prescription Drugs are dispensed by a Nonparticipating Pharmacy, You will be required to:

- Pay the full cost of the Prescription Drug that is dispensed; and
- Submit a claim to HNL for possible reimbursement.

To receive the highest available benefits for Prescription Drugs under this *Certificate*, You must have the Prescription Drug Order dispensed by a Participating Pharmacy, and request that Generic Drugs be substituted for Brand Name Drugs.

Claim forms will be provided by HNL upon request.

Prescription Drugs Dispensed Through the Mail Service Prescription Drug Program

If Your prescription is for a Maintenance Drug, You shall be entitled to have a Prescription Drug Order filled through a mail delivery program selected by HNL. Through this program You can receive through the mail up to a 30-consecutive-calendar-day supply of a Maintenance Drug when so prescribed. In some cases a 30-consecutive-calendar-day supply of medication may not be an appropriate drug treatment plan, according to FDA or HNL usage guidelines. The lesser of the applicable mail order Copayments or Coinsurance or the mail order pharmacy's retail price will be required.

To use this program, You must place an order through the mail by completing a Prescription Mail Order Form. It must be accompanied by the original Prescription Drug Order, not a copy. The Prescription Mail Order Form and an explanation of how to use the program will be provided by HNL upon request. Please contact the Member Services Department at the telephone number on Your HNL ID Card.

Note: Schedule II narcotic drugs are not covered through the mail order program. Refer to the "Outpatient Prescription Drug Benefits" portion of the "General Limitations and Exclusions" section for more information.

When the Health Net PPO Identification Card Is Not In Your Possession

If You need to have a Prescription Drug Order filled by a Participating Pharmacy and have not received a Health Net PPO Identification Card, or it has been lost, or eligibility cannot be determined, You must pay for the drug(s). You may then be entitled to reimbursement in accordance with the terms of this *Certificate*. After the Health Net PPO Identification Card has been received, You must file a claim. Claim forms will be provided by HNL upon request.

GENERAL LIMITATIONS AND EXCLUSIONS

No payment will be made under this *Certificate* for expenses incurred for or in connection with any of the items below, regardless as to whether You utilized the services of a Preferred Provider or an Out-of-Network Provider. Also, services or supplies that are excluded from coverage in the *Certificate*, exceed *Certificate* limitations, or are follow-up care (or related to follow-up care) to *Certificate* exclusions or limitations will not be covered.

Medical Services and Supplies

Not Medically Necessary

Services or supplies which HNL determines are not Medically Necessary, as defined in the “Definitions” section. This includes any services, supplies or expenses received or incurred beyond the scope of Certification given, as described under the “Certification Requirement” portion of the “Plan Benefits” section of this *Certificate*. However, the *Certificate* does cover Medically Necessary services for medical conditions directly related to non-covered services when complications exceed routine follow-up care (such as life-threatening complications of cosmetic surgery).

Excess Charges

Amounts charged by Out-of-Network Providers for covered medical services and treatment which HNL determines to be in excess of the Maximum Allowable Amount, as defined in the “Definitions” section.

Clinical Trials

Although clinical trials are covered, as described in the “Medical Benefits” portion of the “Plan Benefits” section of this *Certificate*, coverage for clinical trials does not include the following items:

- Drugs or devices that are not approved by the FDA;
- Services other than health care services, including but not limited to cost of travel, or costs of other non-clinical expenses;
- Services provided to satisfy data collection and analysis needs which are not used for clinical management;
- Health care services that are specifically excluded from coverage under this *Certificate*; and
- Items and services provided free of charge by the research sponsors to Covered Persons in the trial.

Cosmetic Services and Supplies

Cosmetic surgery or services and supplies performed to alter or reshape normal structures of the body solely to improve the physical appearance of a Covered Person are not covered. However, the *Certificate* does cover Medically Necessary services and supplies for complications which exceed routine follow-up care that is directly related to cosmetic surgery (such as life-threatening complications). In addition, hair transplantation, hair analysis, hairpieces and wigs, cranial/hair prostheses, chemical face peels, abrasive procedures of the skin, liposuction or epilation are not covered.

However, when reconstructive surgery is performed to correct or repair abnormal structures of the body caused by, congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, and such surgery does either of the following:

- Improve function, or
- Create a normal appearance to the extent possible,

Then, the following are covered:

- Surgery to excise, enlarge, reduce or change the appearance of any part of the body;
- Surgery to reform or reshape skin or bone;
- Surgery to excise or reduce skin or tissue; or
- Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.

In addition, when a Medically Necessary mastectomy has been performed, the following are covered:

- Breast reconstruction surgery; and
- Surgery performed on either breast to restore or achieve symmetry (balanced proportions) in the breasts.

Breast reconstruction surgery and dental or orthodontic services for cleft palate procedures are subject to the Certification requirements described in the “Certification Requirement” portion of the “Plan Benefits” section of this *Certificate*. However, Hospital stays related to mastectomies and lymph node dissections will be determined solely by the Physician and Certification for determining the length of stay will not be required.

*The coverage described above in relation to a Medically Necessary mastectomy complies with requirements under the **Women’s Health and Cancer Rights Act of 1998**.*

Contraceptives

Vaginal, oral and emergency contraceptives are covered as described in the “Outpatient Prescription Drug Benefits” portion of the “Plan Benefits” section of this *Certificate*. Vaginal contraceptives include diaphragms and cervical caps, and are only covered when a Physician performs a fitting examination and prescribes the device. Such devices are only available through a prescription from a pharmacy and limited to one fitting and prescription per Calendar Year unless additional fittings or devices are Medically Necessary. Injectable contraceptives (when administered by a Physician) and intrauterine devices (IUDs) are covered as a medical benefit. If Your Physician determines that none of the methods specified as covered by the Plan are medically appropriate, then the Plan will provide coverage for another FDA-approved prescription or contraceptive method as prescribed by Your Physician.

Dental Services

Dental services are limited to the services stated in “Dental Injury” under the “Plan Benefits” section of this *Certificate* and in the following situations:

- General anesthesia and associated facility services are covered when the clinical status or underlying medical condition of the Covered Person requires that an ordinarily non-covered dental service which would normally be treated in a dentist’s office and without general anesthesia must instead be treated in a Hospital or Outpatient Surgical Center. The general anesthesia and associated facility services, must be Medically Necessary, subject to the other limitations and exclusions of this *Certificate* and will only be covered under the following circumstances (a) Covered Persons who are under seven years of age or, (b) Covered Persons who are developmentally disabled or (c) Covered Persons whose health is compromised and general anesthesia is Medically Necessary.
- Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.

Care or treatment of teeth and supporting structures; extraction of teeth; treatment of dental abscess or granuloma; dental examinations and treatment of gingival tissues other than tumors are not covered, except as stated above. Spot grinding, restorative or mechanical devices, orthodontics, inlays or onlays, crowns, bridgework, active splints or orthotics (whether custom fit or not), dental implants (materials implanted into or on bone or soft tissue), or other dental appliances, and related surgeries to treat dental conditions are not covered regardless of reason for such services.

Temporomandibular (Jaw) Joint Disorders

Temporomandibular Joint Disorder (also known as TMD or TMJ disorder) is a condition of the jaw joint which commonly caused headaches, tenderness of the jaw muscles, tinnitus or dull aching facial Pain. These symptoms often result when chewing muscles and jaw joints do not work together correctly. Custom-made oral appliances (intra-oral splint or occlusal splint) and surgical procedures to correct a TMD/TMJ disorder are covered when determined to be Medically Necessary. However, spot grinding, restorative or mechanical devices, orthodontics, inlays or onlays, crowns, bridgework, dental splints, dental implants and other dental appliances to treat dental conditions related to TMD/TMJ disorders are not covered.

Surgery And Related Services For Disorders of the Jaw (often referred to as “Orthognathic Surgery” or “Maxillary and Mandibular Osteotomy”)

Used for the purpose of correcting the malposition or improper development of the bones of the upper or lower jaw, except when such procedures are Medically Necessary. However, spot grinding, restorative or mechanical devices,

orthodontics, inlays or onlays, crowns, bridgework, dental splints (whether custom fit or not), dental implants and other dental appliances are not covered under any circumstances.

Dietary or Nutritional Supplements

Dietary, nutritional supplements and specialized formulas are not covered except when prescribed for the treatment of Phenylketonuria (PKU) (see the "Phenylketonuria (PKU)" provision in the "Plan Benefits" section).

Refractive Eye Surgery

Any eye surgery for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia) and astigmatism, unless Medically Necessary, recommended by the Covered Person's treating Physician and authorized by Us.

Optometrics, Vision Therapy And Orthoptics

Any optometric services, vision therapy, eye exercises including orthoptics, routine eye exams and routine eye refractions. Contact or corrective lenses (except an implanted lens which replaces the organic eye lens), and eyeglasses unless specifically provided elsewhere in this *Certificate*.

Outpatient Speech Therapy

However, outpatient speech therapy in relation to surgery, injury or non-congenital organic disease is not excluded.

Sex Change

Any procedure or treatment designed to alter physical characteristics of the Covered Person to those of the opposite sex, and any other treatment or studies related to sex transformations.

Reconstruction of Prior Surgical Sterilization Procedures

Services to reverse voluntary surgically induced Infertility.

Conception by Medical Procedures

Services or supplies that are intended to impregnate a woman are not covered. Excluded procedures include but are not limited to:

- In-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), artificial insemination, zygote intrafallopian transfer (ZIFT) or any other process that involves the harvesting, transplanting or manipulating of a human ovum. Also not covered are services or supplies, (including injections and injectable medications) which prepare the Covered Person to receive these services.
- Collection, storage or purchase of sperm or ova.

Genetic Testing and Diagnostic Procedures

Genetic testing is covered when determined by HNL to be Medically Necessary. The prescribing Physician must request Prior Authorization for coverage. Genetic testing will not be covered for non-medical reasons or when a Covered Person has no medical indication or family history of a genetic abnormality.

Infertility Services

Services to diagnose, evaluate or treat infertility are not covered.

Experimental Or Investigational Procedures

Experimental or Investigational drugs, devices, procedures or other therapies are only covered when:

- Independent review deems them appropriate as described in the "Independent Medical Review of Investigational or Experimental Therapies" portion of the "General Provisions" section of this *Certificate*; or
- Clinical trials for cancer patients are deemed appropriate according to the "Medical Benefits" portion of the "Plan Benefits" section.

In addition, benefits will also be provided for services and supplies to treat medical complications caused by Experimental or Investigational services or supplies.

Routine Physical Examinations

Routine physical examinations (including psychological examinations or drug screening) that are not medically indicated or physician directed and are obtained for the purposes of checking Your general health in the absence of symptoms or other nonpreventive purpose are not covered. Examples include exams taken to obtain employment, or exams administered at the request of a third party, such as a school, camp or sports organization. Any physical, psychological, vision or hearing exams which are not related to treatment of illness or injury are not covered, except exams for preventive health purposes, as specifically stated under "Preventive Care for Adults" and "Preventive Care for Children" in the "Plan Benefits" section of this *Certificate*.

Immunizations Or Inoculations

For adults or children, except as described in the "Plan Benefits" section of this *Certificate*.

Services Not Related To Covered Illness Or Injury

Any services not related to the diagnosis or treatment of a covered illness or injury.

Custodial Or Domiciliary Care

Regardless of the type of facility. Custodial Care is not covered even when the patient is under the care of a supervising or attending Physician and services are being ordered and prescribed to support and generally maintain the patient's condition, or provide for the patient's comforts, or ensure the manageability of the patient. Furthermore, Custodial Care is not covered even if ordered and prescribed services and supplies are being provided by a registered nurse, a licensed vocational nurse, a licensed practical nurse, a Physician assistant or physical therapist.

Inpatient Diagnostic Tests

Inpatient room and board charges incurred in connection with an admission to a Hospital or other inpatient treatment facility primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Noneligible Hospital Confinements

Inpatient room and board charges in conjunction with a Hospital stay not meeting Medical Necessity and/or primarily for environmental change, personal convenience or custodial in nature are not covered.

Noneligible Institutions

Any services or supplies furnished by a noneligible institution, which is an institution other than a legally operated Hospital or Medicare-approved Skilled Nursing Facility, or which is primarily a place for the aged, a nursing home or any similar institution, regardless of how designated.

Private Rooms

Expenses in excess of a Hospital's (or other inpatient facility's) most common semi-private room rate.

Private Duty Nursing

Inpatient and outpatient services (including incremental nursing) provided by a private duty nurse. Shift care and any portion of shift care services are not covered.

Hyperkinetic Syndromes, Learning Disabilities, Behavioral Problems or Mental Retardation

Regardless of the type of service. However, certain of the above conditions shall be covered as shown in the "Schedule of Benefits" section of this *Certificate*, provided that their level of severity meets the criteria described in the "Definitions" section under "Serious Emotional Disturbances of a Child" and/or "Severe Mental Illness."

Noncovered Items

Any expenses related to the following items, whether authorized by a Physician or not:

- Alteration of Your residence to accommodate Your physical or medical condition, including the installation of elevators
- Disposable supplies for home use
- Exercise equipment, including treadmills and charges for activities or facilities normally intended or used for physical fitness

- Hygienic equipment, Jacuzzis and spas
- Corrective appliances, except prostheses, casts, splints. Surgical dressings, except when the dressing is a primary dressings, i.e., a therapeutic and protective covering applied directly to lesions either on the skin or opening to the skin required as a result of a surgical procedure performed by a Physician
- Foot orthotic devices such as, stockings, corrective shoes and arch supports, except as stated below in the “corrective footwear and foot orthotic devices” provision
- Orthotics, unless custom made to fit the Covered Person’s body. (Orthotics are supports or braces for weak or ineffective joints or muscles.) Corrective footwear and foot orthotic devices are subject to the benefit limitations as stated in the following provision for “corrective footwear”
- Orthodontic appliances to treat dental conditions related to the treatment of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders)
- Corrective footwear and foot orthotic devices (even if custom made) are not covered unless incorporated into a cast, splint, brace or strapping of the foot, unless Your Group purchases a specific benefit for corrective footwear as shown in the “Medical Supplies” portion of the “Schedule of Benefits” section and the “Medically Necessary Corrective Footwear” provision of the “Plan Benefits” section
- Personal or comfort items
- Air purifiers, air conditioners and humidifiers
- Hearing aids
- Food supplements (except as specifically stated in the “Outpatient Infusion Therapy” provision of the “Plan Benefits” section of this *Certificate*)
- Educational services or nutritional counseling, except as specifically provided in the “Diabetes Education” or “Outpatient Infusion Therapy” provisions of the “Plan Benefits” section of this *Certificate*

However, the *Certificate* does cover Medically Necessary diabetic equipment as shown in the “Medical Supplies” portion of “Schedule of Benefits” and the “Diabetic Equipment” provision in the “Plan Benefits” section.

Treatment of Obesity

Treatment or surgery for obesity, weight reduction or weight control, except when provided for morbid obesity.

Transplants

Experimental or Investigational organ, stem cell and tissue transplants.

Duplicate Coverage

If You are covered by more than one plan, benefits will be determined by applying provisions of the “Coordination of Benefits” portion of the “General Provisions” section of this *Certificate*.

Medicare

All benefits provided under this *Certificate* shall be reduced by any amount to which You are entitled under the program commonly referred to as Medicare when federal law permits Medicare to pay before a group health plan.

Workers' Compensation

If You require services for which benefits are in whole or in part either payable or required to be provided under any Workers' Compensation or Occupational Disease Law, HNL will provide covered benefits to which You are entitled and will pursue recovery from the Workers' Compensation carrier liable for the cost of medical treatment related to Your illness or injury.

Expenses Before Coverage Begins

Services received before the Covered Person's Effective Date.

Expenses After Termination of Coverage

Services received after midnight on the effective date of cancellation of coverage under this *Certificate* ends

regardless of when the illness, disease, injury or course of treatment began, except as specifically stated under the "Extension of Benefits" portion of the "Eligibility, Enrollment and Termination" section of this *Certificate*.

Services For Which You Are Not Legally Obligated To Pay

Services for which no charge is made to You in the absence of insurance coverage, except services received at a charitable research Hospital which is not operated by a governmental agency.

Physician Self-Treatment

Self-treatment rendered in a non-emergency. Physician self-treatment occurs when Physicians provide their own medical services, including prescribing their own medication, ordering their own laboratory test and self-referring for their own services. Claims for emergency self-treatment are subject to review by HNL.

Services Provided by Immediate Family Members

Professional services or provider referrals received from a person who lives in Your home or who is related to You by blood, marriage or domestic partnership. Covered Persons who receive routine or ongoing care from a member of their immediate family may be reassigned to another Physician.

Acts of War

Conditions caused by acts of war, whether or not declared.

Crime

Conditions caused by Your commission (or attempted commission) of a felony unless the condition was an injury resulting from an act of domestic violence or an injury resulting from a medical condition.

Nuclear Energy

Conditions caused by release of nuclear energy, when government funds are available.

Governmental Agencies

Any services provided by or for which payment is made by a local, state or federal government agency. This exclusion does not apply to Medi-Cal, Medicaid or Medicare.

Disabled or Hospitalized At The Time of Enrollment

Generally, under the federal Health Insurance Portability and Accountability Act, HNL cannot deny You benefits due to the fact that You are disabled or hospitalized at the time of enrollment. However, if at the time of enrollment You are totally disabled or hospitalized and pursuant to state law You are entitled to an extension of benefits from the insurance carrier providing coverage to Your prior group health plan, benefits of this *Certificate* will be coordinated with benefits payable by the insurance carrier providing coverage to Your prior group health plan, so that not more than 100% of Covered Expenses are provided for services rendered to treat the disabling condition (or condition for which You are hospitalized) under both plans.

For the purposes of coordinating benefits under this *Certificate*, if You are entitled to an extension of benefits from the insurance carrier providing coverage to Your prior group health plan, and state law permits such arrangements, the insurance carrier providing coverage to Your prior group health plan shall be considered the primary plan (paying benefits first) and benefits payable under this *Certificate* shall be considered the secondary plan (paying any excess Covered Expenses), up to 100% of total Covered Expenses.

A Pre-Existing Conditions limitation may apply. Please refer to the "General Limitations and Exclusions" section of Your *Certificate* for details.

Services Related To Pregnancy Induced Under A Surrogate Parenting Agreement

Services for conditions of pregnancy for a surrogate parent are covered, but when compensation is obtained for the surrogacy, We shall have a lien on such compensation to recover its medical expense. A surrogate parent is a woman who agrees to become pregnant with the intent of surrendering custody of the child to another person.

Outpatient Drugs and Medications

Any outpatient drugs, medications or other substances dispensed or administered in any outpatient setting, except as specifically stated in the "Plan Benefits" section of this *Certificate*. This includes any nonprescription (over-the-counter) drug that can be purchased without a prescription (including a drug requiring a prescription but for which there is a non-prescription equivalent), even if a Physician writes a Prescription for a non-Prescription Drug.

Unlisted Services

Any services or supplies not specifically listed in this *Certificate* as Covered Expenses.

Rehabilitative Services

Rehabilitation therapy is limited to services after an acute episode of care for chronic conditions, an acute illness or injury or an acute exacerbation of such an illness or injury. Rehabilitative services, in excess of the number of visits stated in the "Schedule of Benefits" section, whether rendered in an inpatient or outpatient facility, are not covered. In addition, rehabilitation therapy services (physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy) are not covered when provided in connection with the treatment of the following conditions:

- Psychosocial speech delay (includes delayed language development)
- Mental retardation or dyslexia
- Attention deficit disorders and associated behavior problems
- Developmental articulation and language disorders

However, some of the above conditions shall be covered as shown in the "Schedule of Benefits" section, if Medically Necessary as described in the definitions of "Serious Emotional Disturbances of a Child" and/or "Severe Mental Illness," and continuous functional improvement in response to the treatment plan is demonstrated by objective evidence.

Foreign Travel Or Work Assignment

If You receive services or obtain supplies in a foreign country, benefits will be payable for Emergency Services only.

Telephone Consultations

Consultations with a Physician or other provider which are conducted over the telephone.

Home Birth

A birth which takes place at home will be covered only when the criteria for Emergency Care, as defined in this *Certificate*, have been met.

Self-Injectable Drugs

Certain injectable drugs which are considered self-administered are covered on the Specialty Drug tier under the pharmacy benefit. Specialty Drugs are not covered under the medical benefits even if it is administered in a Physician's office. If You need to have a provider administer the Specialty Drug, You will need to obtain the Specialty Drug through the Specialty Pharmacy Vendor and bring it with You to the provider office. Alternatively, You can coordinate delivery of the Specialty Drug directly to the provider's office through the Specialty Pharmacy Vendor.

Aversion Therapy

Therapy intended to change behavior by inducing a dislike for the behavior through association with a noxious stimulus is not covered.

Educational and Employment Services

Services related to educational and professional purposes are not covered, including ancillary services such as:

- Vocational rehabilitation.
- Employment counseling, training or educational therapy for learning disabilities.
- Investigations required for employment.

- Education for obtaining or maintaining employment, or for professional certification.
- Education for personal or professional growth, development or training.
- Academic education during residential treatment.
- Behavioral training

Electro-Convulsive Therapy

Electro-Convulsive therapy is not covered except as authorized by HNL.

Nonabstinence-Based Treatment

Chemical Dependency treatment not based on abstinence is not covered.

Noncovered Treatments

The following types of treatment are only covered when Medically Necessary or when provided in connection with covered treatment for a Mental Disorder or Chemical Dependency:

- Treatment for co-dependency.
- Treatment for psychological stress.
- Treatment of marital or family dysfunction.

Treatment of delirium, dementia, amnesic disorders (as defined in the DSM-IV) and mental retardation other than Medically Necessary Services for accompanying behavioral and/or psychological symptoms if amenable to psychotherapeutic or psychiatric treatment, is not covered.

In addition treatment by providers who are not within licensing categories that are recognized by HNL as providing Covered Services in accordance with applicable medical community standards is not covered.

Nonstandard Therapies

Services that do not meet national standards for professional medical or mental health practice, including, but not limited to, Erhard/The Forum, primal therapy, bioenergetic therapy, sleep therapy, biofeedback (except for certain physical disorders, such as incontinence and chronic pain), hypnotherapy and crystal healing therapy are not covered.

Nontreatable Disorders

Mental Disorders or conditions of Chemical Dependency that HNL determines are not likely to improve with generally accepted methods of treatment are not covered.

Psychological Testing

Psychological testing is only covered, when ordered by a licensed mental health professional and is Medically Necessary to diagnose a Mental Disorder for purposes of developing a mental health treatment plan or when Medically Necessary to treat a Mental Disorder or condition of Chemical Dependency.

Residential Treatment Center

Admissions that are not considered medically appropriate and are not covered include admissions for wilderness center training; for Custodial Care, for a situational or environmental change; or as an alternative to placement in a foster home or halfway house.

State Hospital Treatment

Services in a state Hospital are limited to treatment or confinement as the result of an emergency or Urgently Needed Care as defined in the "Definitions" section.

Treatment Related to Judicial or Administrative Proceedings

Medical, mental health care or Chemical Dependency services as a condition of parole or probation, and court-ordered treatment and testing are limited to Medically Necessary covered services.

Outpatient Prescription Drug Benefits

The exclusions and limitations in the “Medical Services and Supplies” portion of this section also apply to the coverage of Prescription Drugs.

Note: Services or supplies excluded under the Prescription Drug benefits may be covered under Your medical benefits portion of this *Certificate*. Please refer to the “Medical Benefits” portion of the “Plan Benefits” section for more information.

Additional exclusions and limitations:

Drugs Covered by Another Section

Prescription Drugs which are covered by any other benefits provided by this *Certificate*, including any drugs provided for outpatient infusion therapy, delivered or administered to the patient by the attending Physician, or billed by a Hospital or Skilled Nursing Facility, are not covered. This includes immunizing agents.

Noncovered Services

Drugs prescribed for a condition or treatment that is not covered by this *Certificate* are not covered. However, the *Certificate* does cover Medically Necessary drugs for a medical condition directly related to noncovered services when complications exceed routine follow-up care (such as life-threatening complications of cosmetic surgery).

No-Charge Items

Services or supplies for which You are not legally required to pay or for which no charge is made.

Nonprescription (Over-the-Counter) Drugs, Equipment and Supplies

Medical equipment and supplies (including insulin), that are available without a prescription, are covered only when prescribed by a Physician for the management and treatment of diabetes.

Any other non-Prescription Drugs, equipment or supplies which can be purchased without a Prescription Drug Order are not covered even if a Physician writes a prescription for such drug, equipment or supply unless specifically listed in the Recommended Drug List. These are commonly called over-the-counter drugs. Insulin is an exception to this limitation. However, if a higher dosage form of a non-Prescription Drug or over-the-counter drug is only available by prescription, that higher dosage drug will be covered.

If a drug that was previously available by prescription becomes available in an over-the-counter (OTC) form in the same prescription strength, then Prescription Drugs that are similar agents and have comparable clinical effect(s), will only be covered only when Medically Necessary and Prior Authorization is obtained from HNL.

Devices

Coverage is limited to vaginal contraceptive devices and those devices listed under the “Diabetic Supplies” provision of the “Outpatient Prescription Drug Benefits” portion of “Plan Benefits.” No other devices are covered even if prescribed by a Physician.

Diagnostic Drugs

Drugs used for diagnostic purposes are not covered. Diagnostic drugs are covered under the medical benefit when Medically Necessary.

Drugs Prescribed for Cosmetic or Enhancement Purposes

Drugs that are prescribed for the following non-medical conditions are not covered: hair loss, sexual performance, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes and mental performance. Examples of drugs that are excluded when prescribed for such conditions include, but are not limited to, Penlac, Renova, Vaniqua, Propecia or Lustra. This exclusion does not exclude coverage for drugs when pre-authorized as Medically Necessary to treat a diagnosed medical condition affecting memory, including but not limited to, Alzheimer’s dementia.

Appetite Suppressants or Drugs for Body Weight Reduction

Drugs for the treatment of obesity are not covered, unless Medically Necessary.

Dietary or Nutritional Supplements

Drugs used as dietary or nutritional supplements, including vitamins and herbal remedies, including when in combination with a Prescription Drug product, are limited to drugs that are listed in the Recommended Drug List.

Phenylketonuria (PKU) is covered under the medical benefit (see the “Phenylketonuria” provision of the “Plan Benefits” section).

Drugs Prescribed for Common Cold

Drugs when prescribed to shorten the duration of the common cold are not covered.

Allergy Serum

Allergy desensitization products, whether administered by injection or drops placed in the nose or mouth (trans-mucosal absorption), to lessen or end the person's allergic reactions are not covered. These products are sometimes described as “allergy serum.” Allergy serum is covered as a medical benefit. See the “Allergy and Injection Services” portion of the “Schedule of Benefits” section and the “Allergy Testing and Treatment” provision in the “Plan Benefits” section.

Nonapproved Uses, Investigational or Experimental Drugs

Medications limited by law to Investigational use, prescribed for Experimental purposes or prescribed for indications not approved by the Food and Drug Administration are excluded from coverage. However, Off-Label Drugs prescribed or administered by a licensed health care professional for the treatment of a life-threatening or chronic and seriously debilitating condition are covered as described in the “Outpatient Prescription Drug Benefits” portion of the “Plan Benefits” section.

Injectable Drugs

Self-administered injectable drugs as described in the Recommended Drug List are covered. All other injectable drugs are not covered under the Prescription Drug benefit. Surgically implanted drugs are covered under the medical benefit (see the “Surgically Implanted Drugs” provision in the “Plan Benefits” section).

Irrigation Solutions

Irrigation solutions and saline solutions are not covered.

Contraceptives

Oral contraceptives and emergency contraceptives are covered, as described in the “Outpatient Prescription Drug Benefits” portion of the “Plan Benefits” section. Vaginal contraceptives include diaphragms and cervical caps, when a Physician performs a fitting examination and prescribes the device. Such devices are only available through a prescription from a pharmacy and limited to one fitting and prescription per Calendar Year unless additional fittings or devices are Medically Necessary. Injectable contraceptives are covered as a medical benefit when administered by a Physician.

If Your Physician determines that none of the methods specified as covered by the Plan are medically appropriate then the Plan will provide coverage for another FDA approved prescription or contraceptive method as prescribed by Your Physician.

Food and Drug Administration (FDA)

Supply amounts for prescriptions that exceed the FDA's or HNL's indicated usage recommendation are not covered unless Medically Necessary and Prior Authorization is obtained from HNL.

Quantity Limitations

Some drugs are subject to specific quantity limitations per Copayment or Coinsurance, whichever is applicable, based on recommendations for use by the FDA or HNL's usage guidelines. Medications taken on an “as-needed” basis may have a Copayment or Coinsurance based on a specific quantity, standard package, vial, ampoule, tube, or other standard unit. In such a case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply. If Medically Necessary, Your Physician may request a larger quantity from HNL.

Unit Dose or “Bubble” Packaging

Individual doses of medication dispensed in plastic, unit doses or foil packages and dosage forms used for convenience as determined by HNL are not covered, unless Medically Necessary or only available in that form.

Mandatory Mail Order for Maintenance Drugs

Maintenance Drugs must be obtained through the mail order program in order to be covered after the second fill at retail. Maintenance drugs may also be obtained at a CVS retail pharmacy under the mail order program.

Beginning July 31, 2010, you will be required to obtain maintenance medications through the Mandatory Mail Order/Maintenance Choice Program after you have filled your prescription of at least a 30-day supply of a maintenance medication two [2] times from a retail pharmacy. After the second fill of a maintenance medication, you are then required to obtain future refills for a 90-day supply through either the CVS Mail Order Pharmacy or your local retail CVS pharmacy location. You will be charged two retail copayments for the 90-day supply.

The Mandatory Mail Order / Maintenance Choice Pharmacy Program provides you with more convenience for filling your maintenance prescriptions by providing you with up to a 90-day supply of maintenance medications at your mail order copayment.

You can still fill 30-day non-maintenance medications at any Health Net contracted pharmacy.

What is a “Maintenance Medication”?

A maintenance medication is one taken regularly for long-term therapy or chronic conditions, such as high blood pressure, asthma, diabetes or high cholesterol. A list of the maintenance medications that apply to the Mail Order Pharmacy/Maintenance Choice program can be found at www.healthnet.com/My Pharmacy Benefits/View Our Drug Lists/Individual, Family, and Group Maintenance Drug List. Please note that Schedule II narcotic medications [which are medications that have a high abuse risk as classified by the Federal Drug Enforcement Administration] ARE NOT covered through mail order.

You can still fill 30-day non-maintenance prescriptions at any Health Net contracted pharmacy.

How does the program work?

Beginning July 31, 2010, after the second fill of a maintenance medication at a network retail pharmacy, you are required to receive future refills of a 90-day supply using either the CVS Caremark Mail Order Pharmacy or your local retail CVS Pharmacy location. The choice is up to you; the copayment is the same either way. If you have maintenance medication prescriptions at a non-CVS Caremark pharmacy, you will need to transfer them to either a local retail CVS pharmacy or the CVS Caremark Mail Order program.

To obtain maintenance medications through CVS Caremark Mail Order Pharmacy, please complete the following steps:

1. If you have maintenance medication prescriptions at a non-CVS retail pharmacy, you will need to transfer them to the CVS Caremark Mail Order program.
2. Submit the completed Mail Order pharmacy form and the original prescription order [not a copy] written by your physician for a up to 90-day consecutive calendar-day supply of a maintenance medication and;
3. The appropriate copayment amount [two times the retail copayment] or credit card.
4. As an alternate option to Steps 2 & 3, please note that CVS Caremark Mail Order program will call your doctor for you if you call the FastStart program at 1-800-875-0867. Your doctor can also call in a prescription to the CVS Caremark Mail Order program at 1-800-378-5697.

To obtain maintenance medications through a CVS Retail Pharmacy, please complete the following steps:

1. If you have maintenance medication prescriptions at a non-CVS retail pharmacy, you will need to transfer them to CVS Caremark Mail Order program.
2. Present the original Prescription Order [not a copy] written by your physician for up to a 90-day consecutive calendar-day supply of a maintenance medication at a CVS Retail pharmacy. You may contact your doctor who will either provide you with a prescription to take to the pharmacy or will call your local CVS Caremark pharmacy directly with the order. Or, at your request, the CVS Retail Pharmacist will contact your doctor for you to obtain the 90-day prescription order.
3. Your 90-day supply of medication will be dispensed to you at the appropriate copayment amount.

If there are medical reasons why your physician does not want to you have an extended supply of your medication

If there are medical reasons why your physician does not want to you have an extended supply of your maintenance medication, you should contact Health Net Member Services at 1-800-676-6976. A Health Net representative will contact the Health Net pharmacy department to arrange for a continued 30-day supply of your medication through retail if it is deemed medically necessary.

If you have questions or need additional information, please call Health Net Member Services at 1-800-676-6976.

Schedule II Narcotic Drugs

Schedule II narcotic drugs are not covered through mail order. Schedule II drugs are drugs classified by the Federal Drug Enforcement Administration as having a high abuse risk but also safe and accepted for medical uses in the United States.

Compounded Drugs

Compounded Drugs are prescription orders that have at least one ingredient that is Federal Legend or state restricted in a therapeutic amount as Medically Necessary and are combined or manufactured by the pharmacist and placed in an ointment, capsule, tablet, solution, suppository, cream or other form and require a prescription order for dispensing. Compounded Drugs (that use FDA approved drugs for an FDA approved indication) are covered. Coverage for Compounded Drugs is subject to Prior Authorization by the Plan and Medical Necessity. Refer to the "Off-Label Drugs" provision in the "Outpatient Prescription Drugs Benefits" portion of the "Plan Benefits" section for information about FDA approved drugs for off-label use. Coverage for Compounded Drugs requires the Level III Drug Copayment and is subject to Prior Authorization by the Plan and Medical Necessity.

Smoking Cessation

Drugs used to reduce or cease smoking or for nicotine addiction are not covered.

Lost, Stolen or Damaged Drugs

Lost, stolen or damaged drugs are not covered. You will have to pay the retail price for replacing them.

Hypodermic Syringes and Needles

Specific brands of disposable insulin needles, syringes, devices and specific brands of pen devices are covered. Needles and syringes required to administer self-injected medications (other than insulin) will be provided through Our Specialty Pharmacy Vendor under the medical benefit. All other devices, syringes and needles are not covered.

Drugs Prescribed by a Dentist

Drugs prescribed for routine dental treatment are not covered.

GENERAL PROVISIONS

Term Of Certificate

This *Certificate* shall remain in effect for the period of time specified in the Policy held by the Group, subject to the payment of premiums as required and subject to the right of HNL and the Group to terminate or modify it, including the right to change premiums, in accordance with the terms of the Group Policy. Notice of modification or termination will be sent to the holder of the Group Policy. HNL will not provide notice of such changes to Covered Persons of this plan unless it is required to do so by law. The Group may have obligations under state or federal law to provide notification of these changes to the Covered Persons under this plan. Modification shall not affect the right to benefits provided under this *Certificate* in connection with a Hospital confinement commencing prior to such date.

Covered Persons who are hospitalized or totally disabled on the date coverage under this *Certificate* ends may be eligible for continuation of coverage. See the "Conversion Coverage" and "Extension of Benefits" portions of the "Eligibility, Enrollment and Termination" section of this *Certificate*.

Member Services Department Interpreter Services

HNL's Member Services Department has bilingual staff and interpreter services for additional languages to handle Member language needs. Examples of interpretive services provided include explaining benefits, filing a grievance and answering questions related to Your health plan in the Covered Person's preferred language. Also, our Member Services staff can help You find a health care provider who speaks Your language. Call the Member Services number on Your HNL ID card for this free service. HNL discourages the use of family members and friends as interpreters and strongly discourages the use of minors as interpreters at all medical points of contact where a covered benefit or service is received. Language assistance is available at all medical points of contact where a covered benefit or service is accessed. You do not have to use family members or friends as interpreters. If You cannot locate a health care provider who meets Your language needs, You can request to have an interpreter available at no charge.

Covered Persons' Rights and Responsibilities Statement

HNL is committed to treating Covered Persons in a manner that respects their rights, recognizes their specific needs and maintains a mutually respectful relationship. In order to communicate this commitment, HNL has adopted these Covered Persons' rights and responsibilities. These rights and responsibilities apply to Covered Persons' relationships with HNL, its contracting practitioners and providers, and all other health care professionals providing care to its Covered Persons.

Covered Persons have the right to:

- Receive information about HNL, its services, its practitioners and providers and Covered Persons' rights and responsibilities;
- Be treated with respect and recognition of their dignity and right to privacy;
- Participate with practitioners in making decisions about their health care;
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage;
- Request an interpreter at no charge to You;
- Use interpreters who are not Your family members or friends;
- File a grievance in Your preferred language by using the interpreter service or by completing the translated grievance form that is available on www.healthnet.com;
- File a complaint if Your language needs are not met;
- Voice complaints or appeals about the organization or the care it provides; and
- Make recommendations regarding HNL's member rights and responsibilities policies.

Covered Persons have the responsibility to:

- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care;
- Follow plans and instructions for care that they have agreed-upon on with their practitioners; and
- Be aware of their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.

Coordination of Benefits**Explanation**

Benefits provided under this *Certificate* are subject to coordination with benefits payable to You for eligible expenses by any other group coverage including any Hospital, surgical or medical benefit policy, service plan contract, group prepayment plan, coverage through any governmental program or provided by any state or federal statute, as permitted by applicable law.

Purpose

Coordination of Benefits (COB) determines responsibility for payment of eligible expenses among insurers providing group coverage to You, so that the total of all reasonable expenses for Covered Services and Supplies will be paid up to the stated limits of each coverage, but not to exceed total expenses incurred for those services and supplies.

Administration

If You are known to have group coverage through any other health plan or insurer, responsibility for payment of benefits is determined by following the Rules Establishing the Order of Benefits Determination, formulated by the Insurance Commissioner of the State of California and incorporated in this *Certificate*. Such rules determine the order of payment responsibilities between HNL and any other applicable group insurer, by establishing which is the **Primary Plan** and which is the **Secondary Plan**. (For Medicare coordination of benefits, please refer to the "Medicare Coordination of Benefits (COB)" portion of this section.)

The Covered Person's coverage is subject to the same limitations, exclusions and other terms of this Certificate whether HNL is the Primary Plan or the Secondary Plan.

- **COVERED EMPLOYEE:** HNL is the **Primary Plan** with responsibility for first payment, except when (a) You are covered by another group health plan or insurer as the employee and that plan has covered You longer than the HNL plan or (b) the group plan or insurer does not contain a "COB" provision similar to this one.
- **SPOUSE:** HNL is the **Primary Plan** with responsibility for first payment, except when (a) the spouse is covered under another group health plan or insurer as the employee or (b) the other group plan or insurer does not contain a "COB" provision similar to this one.
- **CHILD:** Determination of the **Primary Plan** will be based on the following:
 1. The insurer, under whom the child is covered as a principal Covered Person, employee or primary individual, shall be the **Primary Plan** for that child;
 2. If the child is not covered as specified above and is covered as a dependent under the insurers of both parents, then the insurer of the parent whose date of birth, but not year of birth, occurs earlier in a Calendar Year shall be the **Primary Plan** for dependent children covered under their group health plan. The insurer of the parent whose birthday occurs later in the Calendar Year shall be the **Secondary Plan** for dependent children covered under their group health plan;
 3. Group health plan as determined above is the **Primary Plan** with responsibility for first payment, unless the Rules Establishing the Order of Benefit Determination are affected because of a divorce and assignment of legal custody of the child. **If the Mother has legal custody**, her group plan or insurer pays first; the stepfather's (if any) group plan or insurer pays second; and the natural father's third. **If the Father has legal custody**, his group plan or insurer pays first; the stepmother's (if any) pays second and the natural mother's third; or
 4. However, if the child's parents are separated or divorced and there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses of that child, then the

group health plan of the parent with such court-ordered financial responsibility shall be the **Primary Plan**. The group health plan of the other parent shall be the **Secondary Plan**.

When the points above do not establish an order of benefit determination, the insurer or group health plan who has covered the person for the longer period of time shall be the **Primary Plan** and the other insurer shall be the **Secondary Plan**, provided that:

- The benefits of a group health plan or insurer covering the person as a laid off or retired employee or dependent of such person, shall be determined after the benefits of any other insurer or group health plan covering such person as an employee, other than a laid off or retired employee or dependent of such person; and
- If either group health plan does not have a provision regarding laid off or retired employees, which results in each insurer or group health plan determining its benefits after the other, then the provisions of statement above shall not apply.

Facility of Payment

If payments which should have been made under this *Certificate* are made by any other group health plan or insurer, HNL shall have the right to pay over to such health plan or insurer any amount HNL determines to be warranted in order to satisfy the intent of this provision. Any amounts so paid shall be deemed to be benefits under this *Certificate* and to the extent of such payments, HNL shall be fully discharged from liability under this *Certificate*.

Right to Receive and Release Necessary Information

HNL may obtain or release any information considered to be necessary for "COB" with respect to any person claiming benefits under this *Certificate* without consent of or notice to You or any other person or organization. However, HNL shall not be required to determine the existence of any other group plan or insurer, or the benefits payable under such plan or insurer, when computing benefits due to You covered under this *Certificate*.

Services Instead of Cash Payments

When another group health plan or insurer provides services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an allowable expense and a benefit paid. The reasonable cash value of any services provided to the covered individual by any service organization group plan shall be deemed an expense incurred by the individual and the liability of HNL under this *Certificate* will be reduced accordingly.

Right of Recovery

Whenever HNL's payment for covered services exceeds the maximum amount of payment necessary to satisfy the intent of this provision, HNL shall have the right to recover those excessive amounts from any group health plan, any organization or any persons.

Medicare Coordination of Benefits (COB)

When You or Your spouse reach age 65, You may become eligible for Medicare based on age. You may also become eligible for Medicare before reaching age 65 due to disability or end stage renal disease. We will solely determine whether we are the primary plan or the secondary plan with regard to services to a Covered Person enrolled in Medicare in accordance with the Medicare Secondary Payer rules established under the provisions of Title XVIII of the Social Security Act and its implementing regulations. Generally, those rules provide that:

If You are enrolled in Medicare Part A and Part B, and are not an active employee or Your employer group has less than twenty employees, then this plan will be the secondary plan. Please note that You must enroll in Medicare Part A and Part B to be eligible for Medicare Coordination of Benefits. (If You are not enrolled in Medicare Part A and Part B, HNL will provide coverage for Medically Necessary Covered Services without coordination with Medicare.)

For services and supplies covered under Medicare Part A and Part B, claims are first submitted by Your provider or by You to the Medicare administrative contractor for determination and payment of allowable amounts. The Medicare administrative contractor then sends Your medical care provider a Medicare Summary Notice (MSN), (formerly an Explanation of Medicare Benefits (EOMB)). In most cases, the MSN will indicate that the Medicare administrative contractor has forwarded the claim to HNL for secondary coverage consideration. HNL will process secondary claims received from the Medicare administrative contractor. Secondary claims not received from the Medicare administrative contractor must be submitted to HNL by You or the provider of service, and must include

a copy of the MSN. HNL and/or Your medical provider is responsible for paying the difference between the Medicare paid amount and the amount allowed under this plan for the covered services described in this *Certificate*, subject to any limits established by Medicare COB law. This Plan will cover benefits as a secondary payer only to the extent services are coordinated by Your Physician and authorized by HNL as required under this *Certificate*.

For answers to questions regarding Medicare, contact:

- Your local Social Security Administration office or call **1-800-772-1213**;
- The Medicare Program at **1-800-MEDICARE (1-800-633-4227)**;
- The official Medicare website at www.medicare.gov;
- The Health Insurance Counseling and Advocacy Program (HICAP) at **1-800-434-0222**, which offers health insurance counseling for California seniors; or
- Write to:

Medicare Publications
Department of Health and Human Services
Centers for Medicare and Medicaid Services
6325 Security Blvd.
Baltimore, MD 21207

Grievance and Appeals Process

If You are not satisfied with efforts to solve a problem with HNL or a medical provider, You must first file a grievance or appeal against HNL by calling Member Services at **1-800-676-6976** or by submitting a Member Grievance Form through the HNL website at www.healthnet.com. You must file Your grievance or appeal with HNL within 365 calendar days following the date of the incident or action that caused Your grievance. You may also file a complaint in writing by sending information to:

Health Net Life Insurance Company
Member Services Appeals and Grievance Department
P.O. Box 10348
Van Nuys, CA 91049

The grievance and appeal process as it pertains to a claim dispute, is a 15-calendar day process from the date the initial request was received by HNL, until the close of the case with the Covered Person. If a claim-related dispute resolution determination cannot be issued within the initial 15-calendar day period, HNL will still provide the Covered Person with a complete response based on the facts as then known by HNL within the initial 15-calendar day period. All other non-claim disputes are processed within 30 calendar days. Receipt date is defined as the earliest HNL stamp date or practitioner receipt date noted on the document. If any case exceeds the 15-day or 30-day time limit, a letter is sent to the Covered Person by the 15th or 30th calendar day informing him or her of the reason for the pended status.

There is no requirement that You participate in HNL's grievance or appeals process before requesting Independent Medical Review (IMR) for denials. In such cases, You may contact the California Department of Insurance (CDI) to request an IMR of the denial.

Independent Medical Review of Grievances Involving a Disputed Health Care Service

You may request an independent medical review (IMR) of Disputed Health Care Services from the Department of Insurance (Department) if You believe that health care services eligible for coverage and payment under Your HNL plan have been improperly denied, modified or delayed by HNL. A "Disputed Health Care Service" is any health care service eligible for coverage and payment under Your HNL plan that has been denied, modified or delayed by HNL or one of its contracting providers, in whole or in part because the service is not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that may be available. You will not pay any application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. HNL will provide You with an IMR application form and HNL's grievance response letter that states its position on the Disputed Health Care Service. A decision not to participate in the IMR process may

cause You to forfeit any statutory right to pursue legal action against HNL regarding the Disputed Health Care Service.

Eligibility

Your application for IMR will be reviewed by the Department to confirm that it meets all the eligibility requirements of the law for IMR which are set out below:

- Your provider has recommended a health care service as Medically Necessary, You have received urgent or Emergency Care that a provider determined to have been Medically Necessary; or in the absence of provider recommendation You have been seen by a Physician for the diagnosis or treatment of the medical condition for which You seek IMR;
- The Disputed Health Care Service has been denied, modified or delayed by HNL, based in whole or in part on a decision that the health care service is not Medically Necessary; and
- You have filed a grievance with HNL and the disputed decision is upheld by HNL or the grievance remains unresolved after 30 days. Within the next six months, You may apply to the Department for IMR or later, if the Department agrees to extend the application deadline. If Your grievance requires expedited review You may bring it immediately to the Department's attention. The Department may waive the requirement that You must follow HNL's grievance process in extraordinary and compelling cases.

If Your case is eligible for IMR, the dispute will be submitted to a medical specialist who will make an independent determination of whether or not the care is Medically Necessary. You will receive a copy of the assessment made in Your case from the IMR. If the IMR determines the service is Medically Necessary, HNL will provide benefits for the Disputed Health Care Service in accordance with the terms and conditions of this *Certificate*. If the case is not eligible for IMR, the Department will advise You of Your alternatives.

For non-urgent cases, the IMR organization designated by the Department must provide its determination within 30 days of receipt of the application for review and the supporting documents. For urgent cases involving an imminent and serious threat to Your health, including, but not limited to, serious Pain, the potential loss of life, limb, or major bodily function or the immediate and serious deterioration of Your health, the IMR organization must provide its determination within three business days.

For more information regarding the IMR process or to request an application form, please contact the Member Services Department at the telephone number on Your HNL ID Card.

Independent Medical Review of Investigational or Experimental Therapies

HNL does not cover Experimental or Investigational drugs, devices, procedures or therapies. However, if HNL denies or delays coverage for requested treatment on the basis that it is Experimental or Investigational and You meet the eligibility criteria set out below, You may request an independent medical review (IMR) of HNL's decision from the Department of Insurance.

Eligibility

- You must have a life-threatening or seriously debilitating condition;
- Your Physician must certify to HNL that You have a life-threatening or seriously debilitating condition for which standard therapies have not been effective in improving Your condition or are otherwise medically inappropriate and there is no more beneficial therapy covered by HNL;
- Your Physician must certify that the proposed Experimental or Investigational therapy is likely to be more beneficial than available standard therapies, or as an alternative, You may submit a request for a therapy that, based on documentation presented from medical and scientific evidence, is likely to be more beneficial than available standard therapies;
- You have been denied coverage by HNL for the recommended or requested therapy; and
- If not for HNL's determination that the recommended or requested treatment is Experimental or Investigational, it would be covered.

If HNL denies coverage of the recommended or requested therapy and You meet the eligibility requirements, HNL will notify You within five business days of its decision and Your opportunity to request an external review of

HNL's decision through IMR. HNL will provide You with an application form to request an IMR of HNL's decision. The IMR process is in addition to any other procedures or remedies that may be available. You will not pay any application or processing fees of any kind for IMR. You have the right to provide information in support of Your request for IMR. If Your Physician determines that the proposed therapy should begin promptly, he or she may request expedited review and the experts on the IMR panel will render a decision within seven days of the request. If the IMR panel recommends that HNL cover the recommended or requested therapy, coverage for the services will be subject to the terms and conditions generally applicable to other benefits to which You are entitled. A decision not to participate in the IMR process may cause You to forfeit any statutory right to pursue legal action against HNL regarding the denial of the recommended or requested therapy. For more information, please contact the Member Services Department at the telephone number on Your HNL ID Card.

Arbitration

Sometimes disputes or disagreements may arise between You (including Your enrolled Dependents, heirs or personal representatives) and HNL regarding the construction, interpretation, performance or breach of this *Certificate*, or regarding other matters relating to or arising out of Your HNL membership. Typically such disputes are handled and resolved through the HNL Grievance, Appeal and Independent Medical Review process described above. However, in the event that a dispute is not resolved in that process, HNL uses binding arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise, and whether or not other parties such as employer groups, health care providers, or their agents or employees, are also involved. In addition, disputes with HNL involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

As a condition to becoming a HNL Covered Person, You agree to submit all disputes You may have with HNL, except those described below, to final and binding arbitration. Likewise, HNL agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that both You and HNL are bound to use binding arbitration as the final means of resolving disputes that may arise between the parties, and thereby the parties agree to forego any right they may have to a jury trial on such disputes. However, no remedies that otherwise would be available to either party in a court of law will be forfeited by virtue of this agreement to use and be bound by HNL's binding arbitration process. This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

HNL's binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties. The Federal Arbitration Act, 9 U.S.C. § 1, et seq., will govern arbitrations under this process. In the event that the total amount of damages claimed is \$200,000 or less (\$50,000 or less with respect to disputes with HNL involving alleged professional liability or medical malpractice), the parties shall, within 30 days of submission of the demand for arbitration to HNL, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than \$200,000 or \$50,000, whichever is applicable. In the event that total amount of damages is over \$200,000 or \$50,000, whichever is applicable, the parties shall, within 30 days of submission of the demand for arbitration to HNL, appoint a mutually acceptable panel of three neutral arbitrators (unless the parties mutually agree to one arbitrator), who shall hear and decide the case.

If the parties fail to reach an agreement during this time frame, then either party may apply to a Court of Competent Jurisdiction for appointment of the arbitrator(s) to hear and decide the matter.

Arbitration can be initiated by submitting a demand for arbitration to HNL at the address provided below. The demand must have a clear statement of the facts, the relief sought and a dollar amount.

Health Net Life Insurance Company
Attention: Litigation Administrator
P.O. Box 4504
Woodland Hills, CA 91356-4505

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret this *Certificate*, but will not have any power to change, modify or refuse to enforce any of its terms, nor will the arbitrator have the authority to make any award that would not be available in a court of law. At the conclusion of the arbitration, the arbitrator will issue a written opinion and award setting forth findings of fact and conclusions of law. The award will be final and binding on all parties except to the extent that state or federal law provide for judicial review of arbitration proceedings.

The parties will share equally the arbitrator's fees and expenses of administration involved in the arbitration. Each party also will be responsible for their own attorneys' fees.

Effective July 1, 2002, Covered Persons who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans, are *not* required to submit disputes about certain "adverse benefit determinations" made by HNL to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by HNL to deny, reduce, terminate or not pay for all or a part of a benefit. However, because your employer's plan is not subject to ERISA, the above described types of disputes will be subject to mandatory binding arbitration

Medical Malpractice Disputes

HNL and the health care providers that provide services to You through this plan are each responsible for their own acts or omissions and are ordinarily not liable for the acts or omissions or costs of defending others.

SPECIFIC PROVISIONS

When a Third Party Causes a Covered Person's Injuries

If You are ever injured through the actions of another person (a third party), HNL will provide benefits for all Covered Services and Supplies that You receive through this plan. However, if You receive money because of Your injuries, You must reimburse HNL or the medical providers for the value of any services provided to You under this *Certificate*.

Examples of how an injury could be caused by the actions of another person:

- You were in a car accident and the other driver is at fault; or
- You slip and fall in a store because a wet spot was left on the floor.

Steps the Covered Person Must Take

HNL's legal right to reimbursement is called a lien.

If You are injured because of a third party, You must cooperate with HNL's and the medical providers' efforts to obtain reimbursement, including:

- Telling HNL and the medical providers the name and address of the third party, if You know it, the name and address of his or her lawyer, if he or she is using a lawyer and describing how the injuries were caused;
- Completing any paperwork that HNL or the medical providers may reasonably require to assist in enforcing the lien;
- Promptly responding to inquiries from the lienholders about the status of the case and any settlement discussions;
- Notifying the lienholders immediately upon You or Your lawyer receiving any money from the third parties or their insurance companies; and
- Holding any money that You receive from the third parties or their insurance companies, in trust and reimbursing HNL and the medical providers for the amount of the lien as soon as You are paid by the third party.

How the Amount of the Covered Person's Reimbursement is Determined

Your reimbursement to HNL or the medical provider under this lien is based on the value of the services received and the costs of perfecting this lien. For the purposes of determining the lien amount, the value of the services depends on how the provider was paid and will be determined as permitted by law. Unless the money received came from a Workers' Compensation claim, the following applies:

- The amount of the reimbursement owed to HNL or the medical provider will be reduced by the percentage that the recovery is reduced if a judge, jury or arbitrator determines that You were responsible for some portion of Your injuries;
- The amount of the reimbursement owed HNL or the medical provider will also be reduced by a prorata share for any legal fees or costs paid from money You received; and
- The amount You will be required to reimburse HNL or the medical provider for services received under this plan will not exceed one-third of the money You receive if You engage a lawyer or one-half of the money received if a lawyer is not engaged.

Refund To HNL of Overpayment Of Benefits

If We pay health benefits for expenses incurred on account of You or Your Dependent, You or any other person or organization that was paid must make a refund to Us if:

- All or some of the expenses were not paid by You or Your Dependent or did not legally have to be paid;
- All or some of the payment made by Us exceeded the benefits under the *Certificate*; or
- All or some of the expenses were recovered from or paid by a source other than this *Certificate*. This may include payments made as a result of claims against a third party of negligence, wrongful acts or omissions.

The refund equals the amount We paid in excess of the amount it should have paid under this *Certificate*. In the case of recovery from or payment by a source other than this *Certificate*, the refund equals the amount of the recovery or payment up to the amount We paid.

If the refund is due from another person or organization, You and Your Dependent agree to help Us get the refund when requested.

If You, or any other person or organization that was paid, do not promptly refund the full amount, We may reduce the amount of any future benefits that are payable under this *Certificate*. The reduction will equal the amount of the required refund.

Out-of-State Providers

Health Net PPO has created a program which allows Covered Persons access to participating providers outside their state of residence. This program is through the out-of-state provider network shown on Your HNL ID Card and is limited to Covered Persons traveling outside their state of residence.

If You are traveling outside Your state of residence, require medical care or treatment, and use a provider from the out-of-state provider network, Your out-of-pocket expenses may be lower than those incurred when You use an Out-of-Network Provider.

When You obtain services outside Your state of residence through the out-of-state provider network, You will be subject to the same Copayments, Coinsurances, Deductibles, maximums and limitations as You would be if You obtained services from a Preferred Provider in Your state of residence. There is the following exception: Covered Expenses will be calculated based on the lower of (i) the actual billed charges or (ii) the charge that the out-of-state provider network is allowed to charge, based on the contract between HNL and the network. In a small number of states, local statutes may dictate a different basis for calculating Your Covered Expenses.

Second Medical Opinion

When requested by a Covered Person or participating health professional who is treating a Covered Person, We will authorize a second opinion by an appropriately qualified health care professional. Reasons for a second opinion include, but are not limited to, the following:

- If the Covered Person questions the reasonableness or necessity of recommended surgical procedures.
- If the Covered Person questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious Chronic condition.
- If clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition and the Covered Person requests an additional diagnosis.
- If the treatment plan in progress is not improving the medical condition of the Covered Person within an appropriate period of time given the diagnosis and plan of care, and Covered Person requests a second opinion regarding the diagnosis or continuance of the treatment.
- If the Covered Person has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

As used above, an appropriately qualified health care professional is a Physician or a specialist who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, injury, condition or conditions associated with the request for a second opinion.

To request an authorization for a second opinion, contact the Member Services Department at the telephone number on the HNL ID Card. We will review the request in accordance with HNL's procedures and timelines as stated in the second opinion policy. For more information on the second opinion policy, please contact the Member Services Department.

If We deny a request by a Covered Person for a second opinion, We will notify the Covered Person in writing of the reasons for the denial and will inform the Covered Person of the right to dispute the denial, and the procedures for exercising that right.

MISCELLANEOUS PROVISIONS

Form or Content of the Certificate

No agent or employee of HNL is authorized to change the form or content of this *Certificate*. Any changes can be made only through an endorsement authorized and signed by an officer of HNL.

Benefits Not Transferable

No person other than You is entitled to receive benefits to be furnished by HNL under this *Certificate*. Such right to benefits is not transferable. **Fraudulent use of such benefits will result in cancellation of Your eligibility under this *Certificate* and appropriate legal action.**

Time Limit on Certain Defenses

After this *Certificate* has been in force for a period of two years, no statements, except fraudulent misstatement, made by the Group contained in the application and no statements relating to insurability made by any Covered Person eligible for coverage under this *Certificate* can be contested or used to deny any claim.

Notice of Claim

Written notice of claim must be given to Us within 20 days after the occurrence or commencement of any covered loss, or as soon thereafter as reasonably possible. Notice may be given to Us at 21281 Burbank Blvd., Woodland Hills, CA 91367, or to any of Our authorized agents or mailed to Us at P.O. Box 9103, Van Nuys, CA 91409-9103. Notice should include information sufficient for Us to identify the Covered Person.

Claim Forms

When We receive notice of a claim, We will furnish You with Our usual forms for filing proof of loss. If We do not do so within 15 days, You can comply with the requirements for furnishing proof of loss by submitting written proof within the time fixed in this *Certificate* for filing such proofs of loss. Such written proof must cover the occurrence, the character and the extent of the loss.

Proofs of Loss

Written proof of loss on account of disability (where periodic payments depend upon continuing loss), must be given to Us at 21281 Burbank Blvd., Woodland Hills, CA 91367, within 90 days after the end of the period of time for which claim is made; in the case of claim for any other loss, written proof of loss must be furnished within 90 days after the date of the loss. Failure to furnish such proof within the time required will not invalidate or reduce any claim if proof is furnished as soon as reasonably possible. Except in the absence of legal capacity, however, We are not required to accept proofs more than one year from the time proof is otherwise required.

Expenses for Copying Medical Records

We will reimburse the Covered Person or provider for reasonable expenses incurred in copying medical records requested by Us.

Time of Payment of Claims

We will pay benefits promptly upon receipt of due written proof of loss.

Cash Benefits

In most instances, You will not need to file a claim when You receive Covered Services and Supplies from a Preferred Provider. If you use an Out-of-Network Provider and file a claim, HNL will reimburse You for the amount You paid for Covered Expenses, less any applicable Deductible, Copayment or Coinsurance. If You signed an assignment of benefits and the provider presents it to Us, We will send the payment directly to the provider. You must provide proof of any amounts that You have paid.

If a parent who has custody of a child submits a claim for cash benefits on behalf of the child who is subject to a Medical Child Support Order, HNL will send the payment to the custodial parent.

Payment to Providers or Covered Persons:

- **Direct Payment.** Benefit payment for Covered Expenses will be made directly to:
 1. **Contracting Hospitals:** Hospitals which have Provider Service Agreements with HNL to provide services to Covered Persons.

2. **Providers of Ambulance transportation and certified nurse midwives:** As required by the California Insurance Code, this must occur, even if written assignment has not been made by You. However, if the submitted provider's statement or bill indicates that the charges have been paid in full, payment will be made to You.
 3. **Other providers of service not mentioned above, Hospital and professional:** when You assign benefits to them in writing.
- **Joint Payment.** Benefit payment for Covered Expenses will be made jointly to other providers and You:
 1. When a written assignment stipulates joint payment.
 2. When the benefit payment is \$2,000 or greater and the submitted bill indicates that there is a balance due.
 3. Joint payment will not be made to contracting Hospitals and providers of Ambulance services. Payment to them will be direct as described in "Direct Payment" provision above.
 - **Direct Payment to You.** In situations not described above, payment will be made to You.

Payment When You Are Unable To Accept

If a claim is unpaid at the time of Your death or if You are not legally capable of accepting it, it will be paid to Your estate or any relative or person who may legally accept on Your behalf.

Physical Examination

HNL, at its expense, has the right to examine or request an examination of any Covered Person whose injury or sickness is the basis of a claim as often as is reasonably required while the claim is pending.

Foreign Travel or Work Assignment

Benefits will be provided for Emergency Care received in a foreign country. Determination of Covered Expenses will be based on the amount that is no greater than the Maximum Allowable Amount (as determined by HNL) in the USA for the same or a comparable service. The Maximum Allowable Amount is defined in the "Definitions" section.

Workers' Compensation Insurance

This *Certificate* is not in lieu of and does not affect any requirement for, or coverage by, Workers' Compensation Insurance.

Notice

Any notice required of HNL shall be sufficient if mailed to the holder of the Group Policy at the address appearing on the records of HNL. This *Certificate*, however, will be posted electronically on HNL's website at www.healthnet.com. The Group can opt for the Covered Person to receive this *Certificate* online. By registering and logging on to HNL's website, Covered Persons can access, download and print this *Certificate*, or can choose to receive it by U.S. mail, in which case HNL will mail this *Certificate* to each Covered Person's address on record.

If notice is required of You or the Group, it will be sufficient if mailed to the HNL office at the address listed on the back cover of this *Certificate*.

Interpretation of Certificate

The laws of the State of California shall be applied to interpretations of this *Certificate*.

Legal Actions

No action at law or in equity may be brought to recover benefits prior to the expiration of 60 days after written Proof of Loss has been furnished. No such action may be brought after a period of 3 years (or the period required by law, if longer) after the time limits stated in the Proofs of Loss section.

Non-Regulation of Providers

This Health Net PPO plan does not regulate the amounts charged by providers of medical care, except to the extent that the rates for the Covered Services and Supplies are negotiated with Preferred Providers.

Free Choice of Provider

This Health Net PPO plan does not interfere with Your right to select any properly licensed Hospital, Physician or other health care professional or facility that provides services or supplies covered by this plan. However, Your choice of provider may affect the amount of benefits payable.

Continuity of Care

If HNL's contract with a Preferred Provider is terminated, You may elect continued care by that provider if, at the time of termination, You were receiving care for an acute condition, serious chronic condition, pregnancy, newborn, terminal illness or a scheduled surgery. For more information on how to request continued care, please contact the Member Services Department at the telephone number on Your HNL ID Card.

Providing of Care

HNL is not responsible for providing any type of Hospital, medical or similar care. HNL is also not responsible for the quality of any type of Hospital, medical or similar care.

Relationship of Parties

The relationship, if any, between HNL and any health care providers is that of an independent contractor relationship. Physicians, Hospitals, Skilled Nursing Facilities and other health care providers and community agencies are not agents or employees of HNL. HNL shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by You while receiving care from any health care provider. Neither the Group nor any Covered Person is the agent or representative of HNL. Neither shall be liable for any acts or omissions of HNL, its agents or employees.

HNL retains the right to designate or replace an administrator to perform certain functions for providing the Covered Services and Supplies of this *Certificate*. If HNL does designate or replace any administrator, HNL will inform You of all new procedures. Any administrator designated by HNL is an independent contractor and not an employee or agent of HNL.

Confidentiality of Medical Records

A STATEMENT DESCRIBING HNL'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Health Care Plan Fraud

Health care plan fraud is a felony that can be prosecuted. Any person who willfully and knowingly engages in an activity intended to defraud the health care plan by filing a claim that contains a false or deceptive statement is guilty of insurance fraud.

Your Responsibility

As a Covered Person, You must:

- File accurate claims. If someone else, such as Your spouse or another Dependent who is a Covered Person, files claims on Your behalf, You should review the form before You sign it;
- Review the explanation of benefits (EOB) form when it is returned to You. Make certain that benefits have been paid correctly based on Your knowledge of the expenses incurred and the services rendered;
- Never allow another person to seek medical treatment under Your identity. If Your ID Card is lost, You should report the loss to Us immediately; and
- Provide complete and accurate information on claims forms and any other information forms. Attempt to answer all questions to the best of Your knowledge.

To maintain the integrity of Your health plan, We encourage You to notify Us whenever a provider:

- bills You for services or treatments that You have never received;
- asks You to sign a blank claim form; or
- asks You to undergo tests that You feel are not needed.

If You are concerned about any of the charges that appear on a bill or Explanation of Benefits form, or if You know of or suspect any illegal activity, call Our toll-free hotline at the number shown on Your HNL ID card. All calls are strictly confidential.

Privacy Statement

HNL wants You to understand how We protect Your privacy when We collect and use information about Covered Persons, and the measures that We take to safeguard that information. These provisions apply to both current and former Covered Persons, unless We state otherwise.

Information Security

The only individuals who are authorized to have access to nonpublic personal information about Covered Persons ("Covered Person Information") are those individuals who need it to perform their job responsibilities or to provide products or services to Covered Persons. For example, We may access Covered Person Information to offer other compatible products or services We provide, to process requests We receive from a Covered Person and to administer Our products or services. Our employees are required to maintain the confidentiality of Covered Person Information and to follow the policies and procedures We establish to secure such information. In addition, We maintain physical, electronic and procedural security measures to safeguard Covered Person Information.

Information We Collect

As part of providing Covered Persons with Our services and products, We obtain and collect Covered Person Information about a Covered Person, including:

- Information We receive from the Covered Person on applications or other forms (such as the Covered Person's name, address, telephone number, social security number, account information, employment, health status and other personal information relevant to the Covered Person's coverage); and
- Information about the Covered Person's transactions with Us, Our affiliates or others (such as information about premium payment history, co-payments, claims payments, co-insurance and Deductibles).

Although We collect such information primarily from applications and forms, We may also collect information through other means, such as telephone conversations, web sites and through third parties, such as employers, Physicians, Hospitals and other medical providers. We may also collect such information from Internet "cookies" which may be used to track web site usage, remember passwords and provide the Covered Person with web site content specific to the Covered Person's needs and interests.**

Disclosures

We do not disclose any Covered Person Information about a Covered Person or Our former Covered Person to anyone, except as permitted by law. We may disclose all of the information We collect, as described above in the "Information We Collect" section. For example, Covered Person Information will or may be disclosed for purposes such as to provide services to Covered Persons; to coordinate with reinsurance and excess or stop loss insurers; to enforce a Covered Person's rights; to protect against actual or potential fraud; to resolve Covered Person inquiries or disputes; to carry out Our business; to protect the confidentiality or security of Our records; to administer preventive health and case management programs; to perform underwriting, auditing and ratemaking functions; to enable Our service providers to perform marketing on Our behalf to inform Covered Persons about Our own products or services; to allow Our health insurance affiliate to provide Covered Persons with information about Medicare supplement products; and to comply with federal or state laws and other applicable legal requirements.

Additional Information about this Privacy Statement

The policies indicated in this privacy statement will remain effective, even if the Covered Person's coverage is terminated, to the extent We retain Covered Person Information about the Covered Person. We may change this privacy statement at any time and will inform the Covered Person of any changes as required by law or regulation.

**Information We collect through Our Internet web site is subject to Our Web privacy statement, which is available on Our web site at www.healthnet.com.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION AND NONPUBLIC PERSONAL FINANCIAL INFORMATION* ABOUT YOU MAY BE USED AND DISCLOSED. THIS NOTICE ALSO DESCRIBES HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice tells You about the ways in which Health Net Life (referred to as “We” or “the Plan”) may collect, use and disclose Your protected health information and Your rights concerning Your protected health information. “Protected health information” is information about You, including demographic information, that can reasonably be used to identify You and that relates to Your past, present or future physical or mental health or condition, the provision of health care to You or the payment for that care.

We are required by federal and state laws to provide You with this Notice about Your rights and Our legal duties and privacy practices with respect to Your protected health information. We must follow the terms of this Notice while it is in effect. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

How We May Use And Disclose Your Protected Health Information

We may use and disclose Your protected health information for different purposes. The examples below are provided to illustrate the types of uses and disclosures We may make without Your authorization for payment, health care operations and treatment.

- **Payment.** We use and disclose Your protected health information in order to pay for Your covered health coverage or expenses. For example, We may use Your protected health information to process claims to be reimbursed by another insurer that may be responsible for payment or for premium billing.
- **Health Care Operations.** We use and disclose Your protected health information in order to perform Our plan activities, such as quality assessment activities or administrative activities, including data management or customer service.
- **Treatment.** We may use and disclose Your protected health information to assist Your health care providers (doctors, pharmacies, Hospitals and others) in Your diagnosis and treatment. For example, We may disclose Your protected health information to providers to provide information about alternative treatments.
- **Plan Sponsor.** If You are enrolled through a group health plan, We may provide non-identifiable summaries of claims and expenses for enrollees in Your group health plan to the plan sponsor, which is usually the employer. If the plan sponsor provides plan administration services, We may also provide access to identifiable health information to support its performance of such services which may include but are not limited to claims audits or customer services functions. We will only share health information upon a certification from the plan sponsor representing there are restrictions in place to ensure that only plan sponsor employees with a legitimate need to know will have access to health information in order to provide plan administration functions.

We may also disclose protected health information to a person, such as a family member, relative, or close personal friend, who is involved with Your care or payment. We may disclose the relevant protected health information to these persons if You do not object or we can reasonably infer from the circumstances that You do not object to the disclosure; however, when You are not present or are incapacitated, we can make the disclosure if, in the exercise of professional judgment, we believe the disclosure is in Your best interest.

Other Permitted Or Required Disclosures

- **As Required by Law.** We must disclose protected health information about You when required to do so by law.
- **Public Health Activities.** We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury or disability.
- **Victims of Abuse, Neglect or Domestic Violence.** We may disclose protected health information to government agencies about abuse, neglect or domestic violence.
- **Health Oversight Activities.** We may disclose protected health information to government oversight agencies (e.g., California Department of Health Services) for activities authorized by law.

- **Judicial and Administrative Proceedings.** We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about You in certain cases in response to a subpoena, discovery request or other lawful process.
- **Law Enforcement.** We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.
- **Coroners, Funeral Directors, Organ Donation.** We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties. We may also disclose protected health information in connection with organ or tissue donation.
- **Research.** Under certain circumstances, We may disclose protected health information about You for research purposes, provided certain measures have been taken to protect Your privacy.
- **To Avert a Serious Threat to Health or Safety.** We may disclose protected health information about You, with some limitations, when necessary to prevent a serious threat to Your health and safety or the health and safety of the public or another person.
- **Special Government Functions.** We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.
- **Workers' Compensation.** We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.

Other Uses Or Disclosures With An Authorization

Other uses or disclosures of Your protected health information will be made only with Your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that We have already taken action on the information disclosed or if We are permitted by law to use the information to contest a claim or coverage under the Plan.

Your Rights Regarding Your Protected Health Information

You have certain rights regarding protected health information that the Plan maintains about You.

- **Right To Access Your Protected Health Information.** You have the right to review or obtain copies of Your protected health information records, with some limited exceptions. Usually the records include enrollment, billing, claims payment and case or medical management records. Your request to review and/or obtain a copy of Your protected health information records must be made in writing. We may charge a fee for the costs of producing, copying and mailing Your requested information, but We will tell You the cost in advance.
- **Right To Amend Your Protected Health Information.** If You feel that protected health information maintained by the Plan is incorrect or incomplete, You may request that We amend the information. Your request must be made in writing and must include the reason You are seeking a change. We may deny Your request if, for example, You ask Us to amend information that was not created by the Plan, as is often the case for health information in Our records, or You ask to amend a record that is already accurate and complete.

If We deny Your request to amend, We will notify You in writing. You then have the right to submit to Us a written statement of disagreement with Our decision and We have the right to rebut that statement.

- **Right to an Accounting of Disclosures by the Plan.** You have the right to request an accounting of disclosures We have made of Your protected health information. The list will not include Our disclosures related to Your treatment, Our payment or health care operations, or disclosures made to You or with Your authorization. The list may also exclude certain other disclosures, such as for national security purposes.

Your request for an accounting of disclosures must be made in writing and must state a time period for which You want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form You want the list (for example, on paper or electronically). The first accounting that You request within a 12-month period will be free. For additional lists within the same time period, We may charge for providing the accounting, but We will tell You the cost in advance.

- **Right To Request Restrictions on the Use and Disclosure of Your Protected Health Information.** You have the right to request that We restrict or limit how We use or disclose Your protected health information for

treatment, payment or health care operations. **We may not agree to Your request.** If We do agree, We will comply with Your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In Your request, You must tell Us (1) what information You want to limit; (2) whether You want to limit how We use or disclose Your information, or both; and (3) to whom You want the restrictions to apply.

- **Right To Receive Confidential Communications.** You have the right to request that We use a certain method to communicate with You about the Plan or that We send Plan information to a certain location if the communication could endanger You. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from Us could endanger You. We will accommodate all reasonable requests. Your request must specify how or where You wish to be contacted.
- **Right to a Paper Copy of This Notice.** You have a right at any time to request a paper copy of this Notice, even if You had previously agreed to receive an electronic copy.
- **Contact Information for Exercising Your Rights.** You may exercise any of the rights described above by contacting Our Privacy Office. See the end of this Notice for the contact information.

Health Information Security

HNL requires its employees to follow the HNL security policies and procedures that limit access to health information about Covered Persons to those employees who need it to perform their job responsibilities. In addition, HNL maintains physical, administrative and technical security measures to safeguard Your protected health information.

Changes To This Notice

We reserve the right to change the terms of this Notice at any time, effective for protected health information that We already have about You as well as any information that We receive in the future. We will provide You with a copy of the new Notice whenever We make a material change to the privacy practices described in this Notice. We also post a copy of Our current Notice on Our website at www.healthnet.com. Any time We make a material change to this Notice, We will promptly revise and issue the new Notice with the new effective date.

Complaints

If You believe that Your privacy rights have been violated, You may file a complaint with Us and/or with the Secretary of the Department of Health and Human Services. All complaints to the Plan must be made in writing and sent to the Privacy Office listed at the end of this Notice.

We support Your right to protect the privacy of Your protected health information. **We will not retaliate against You or penalize You for filing a complaint.**

Contact The Plan

If You have any complaints or questions about this Notice or You want to submit a written request to the Plan as required in any of the previous sections of this Notice, You may send it in writing to:

Address: Health Net Life Privacy Office
Attention: Director, Information Privacy
P.O. Box 9103
Van Nuys, CA 91409

You may also contact Us at:

Telephone: **1-800-676-6976**
Fax: **1-818-676-8314**
Email: Privacy@healthnet.com

* *Nonpublic personal financial information includes personally identifiable financial information that You provided to us to obtain health plan coverage or we obtained in providing benefits to You. Examples include Social Security numbers, account balances and payment history. We do not disclose any nonpublic personal information about You to anyone, except as permitted by law.*

DEFINITIONS

This section defines words that will help You understand Your Plan. These words appear throughout this *Certificate* with the initial letter of the word in capital letters.

Accidental Injury is physical harm or disability which is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental Injury does not include illness, infection (except infection of a cut or nonsurgical wound) or damage to the teeth or dental prosthesis caused by chewing.

Ambulance means an automobile or airplane (fixed wing or helicopter), which is specifically designed and equipped for transporting the sick or injured. It must have patient care equipment, including at least a stretcher, clean linens, first aid supplies and oxygen equipment. It must be staffed by at least two persons who are responsible for the care and handling of patients. One of these persons must be trained in advanced first aid. The vehicle must be operated by a business or agency which holds a license issued by a local, state or national governmental authority authorizing it to operate Ambulances.

Ambulatory Surgical Center is a freestanding outpatient surgical facility. It must be licensed as an outpatient clinic according to state and local laws, and must meet all requirements of an outpatient clinic providing surgical services. It must also meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Association of Ambulatory Health Care.

Average Wholesale Price for any Prescription Drug is the amount listed in a national pharmaceutical pricing publication, and accepted as the standard price for that drug by HNL.

Bariatric Surgery Performance Center is a provider in HNL's designated network of California bariatric surgical centers and surgeons that perform weight loss surgery. Preferred Providers that are not designated as part of HNL's network of Bariatric Surgery Performance Centers are considered Out-of-Network Providers for purposes of determining coverage and benefits for weight loss surgery.

Blood Products are biopharmaceutical products derived from human blood, including but not limited to, blood clotting factors, blood plasma, immunoglobulins, granulocytes, platelets and red blood cells.

Brand Name Drug is a Prescription Drug or medicine that has been registered under a brand or trade name by its manufacturer and is advertised and sold under that name, and indicated as a brand in the Medi-Span or similar national Database.

Calendar Year is the twelve-month period that begins at 12:01 a.m. Pacific Time on January 1 of each year.

Calendar Year Deductible is the amount of medical Covered Expenses which must be incurred by You each Calendar Year and for which You have payment responsibility before benefits become payable by HNL.

Certification refers to the process for certain Covered Expenses that require review and approval, frequently prior to the expense being incurred. The "Schedule of Benefits" section of this *Certificate* shows the penalties applicable to those expenses which are authorized in accordance with the provisions of this *Certificate*, and those expenses which require review and approval, prior to the expenses being incurred which are not so certified. The requirements for Certification are described in the "Certification Requirement" portion of the "Plan Benefits" section of this *Certificate*.

Chemical Dependency is alcoholism, drug addiction or other chemical dependency problems.

Coinsurance is the percentage of the Covered Expenses for which You are responsible, as specified in the "Schedule of Benefits" section.

Compounded Drugs are prescription orders that have at least one ingredient that is Federal Legend in a therapeutic amount and are combined or manufactured by the pharmacist and placed in an ointment, capsule, tablet, solution, suppository, cream or other form and require a prescription order for dispensing.

Contracted Chiropractor is a doctor of chiropractic (D.C.), licensed by the state of California, who has a contract in effect with American Specialty Health Plans (ASH Plans) to provide the chiropractic benefits of this Plan.

Contracted Rate is the rate that Preferred Providers are allowed to charge You, based on a contract between HNL and such provider. Covered Expenses for services provided by a Preferred Provider will be based on the Contracted Rate.

Copayment is a fixed dollar fee charged to You for Covered Services and Supplies when You receive them. The amount of each Copayment is indicated in the "Schedule of Benefits" section.

Covered Expenses are the maximum charges for which HNL will pay benefits for each covered service or supply (including covered services related to Mental Disorders and Chemical Dependency). The amount of Covered Expenses varies by whether You obtain services from a Preferred Provider or an Out-of-Network Provider. Covered Expenses are the lesser of the billed charge or: (i) the Contracted Rate for the services or supplies provided by a Preferred Provider; (ii) the Maximum Allowable Amount for the services or supplies provided by an Out-of-Network Provider.

Covered Person is the enrolled employee (referred to as "You" or "Your" or the "principal Covered Person") or his or her Dependent who is covered under this *Certificate*.

Covered Services and Supplies means Medically Necessary services and supplies that are payable or eligible for reimbursement, subject to any Deductibles, Copayments, Coinsurance, benefit limitations or maximums, under the *Certificate*.

Custodial Care is care that is rendered to a patient to assist in support of the essentials of daily living such as help in walking, getting in and out of bed, bathing, dressing, feeding, preparation of special diets and supervision of medications which are ordinarily self-administered, and for which the patient:

- Is disabled mentally or physically and such disability is expected to continue and be prolonged;
- Requires a protected, monitored or controlled environment whether in an institution or in the home; and
- Is not under active and specific medical, surgical or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored or controlled environment.

Deductible is a set amount you pay for specified Covered Services and Supplies before HNL pays any benefits for those Covered Services and Supplies.

Dependents are individuals who meet the eligibility requirements for coverage under this *Certificate* and have been enrolled by the principal Covered Person (employee).

Domestic Partner is a person eligible for coverage provided that the partnership with the principal Covered Person meets all domestic partnership requirements under California law or other recognized state or local agency.

The Domestic Partner and principal Covered Person must:

1. Have a common residence. It is not necessary that the legal right to possess the common residence be in both names.
2. Not be married or a member of another domestic partnership with someone else that has not been terminated, dissolved or judged a nullity.
3. Not be related by blood in a way that would prevent them from being married to each other in this state.
4. Be at least 18 years of age.
5. Be capable of consenting to the domestic partnership.
6. Be either of the following:
 - Members of the same sex; or
 - Members of the opposite sex and one or both be eligible for Social Security benefits and one or both be over the age of 62.
7. Both file a Declaration of Domestic Partnership with the Secretary of State or an equivalent document with another recognized state or local agency, or both are persons of the same sex who have validly

formed a legal union other than marriage in a jurisdiction outside of California which is substantially equivalent to a Domestic Partnership as defined under California law.

(The requirements listed above are statutory eligibility requirements. Your Group's Domestic Partner eligibility requirements may be less restrictive.)

Durable Medical Equipment

- Serves a medical purpose (its reason for existing is to fulfill a medical need, and it is not useful to anyone in the absence of illness or injury);
- Withstands repeated use; and
- Fulfills basic medical needs, as opposed to satisfying personal preferences regarding style and range of capabilities.

Effective Date is the date on which You become covered or entitled to benefits under this *Certificate*.

Emergency Care is any otherwise covered service for an acute illness, a new injury or an unforeseen deterioration or complication of an existing illness, injury or condition already known to the person or, if a minor, to the minor's parent or guardian that a reasonable person with an average knowledge of health and medicine, (a prudent layperson) would seek if he or she was having serious symptoms (including symptoms of Severe Mental Illness and Serious Emotional Disturbances of a Child), and believed that without immediate treatment, any of the following would occur:

- His or her health would be put in serious danger (and in the case of a pregnant woman, would put the health of her unborn child in serious danger);
- His or her bodily functions, organs or parts would become seriously damaged; or
- His or her bodily organs or parts would seriously malfunction.

Emergency Care also includes treatment of severe Pain or active labor. Active labor means labor at the time that either of the following would occur:

- There is inadequate time to effect safe transfer to another Hospital prior to delivery; or
- A transfer poses a threat to the health and safety of the Covered Person or unborn child.

Emergency Care includes Ambulance and Ambulance transport services provided through the "911" emergency response system, if the request was made for Emergency Care.

Emergency Care will also include additional screening, examination and evaluation by a Physician (or other health care provider acting within the scope of his or her license) to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate such condition, within the capability of the facility.

HNL will make any final decisions about Emergency Care. See "Independent Medical Review of Grievances Involving a Disputed Health Care Service" under "General Provisions" for the procedure to request an Independent Medical Review of a Plan denial of coverage for Emergency Care.

Experimental is any procedure, treatment, therapy, drug, biological product, equipment, device or supply which HNL has not determined to have been demonstrated as safe, effective or medically appropriate and which the United States Food and Drug Administration (FDA) or Department of Health and Human Services (HHS) has determined to be Experimental or Investigational or is the subject of a clinical trial.

Please refer to "Independent Medical Review of Investigational or Experimental Therapies" in the "General Provisions" section as well as the "Medical Benefits" portion of the "Plan Benefits" section of this *Certificate* for additional information.

Generic Drug is the pharmaceutical equivalent of a Brand Name Drug whose patent has expired and is available from multiple manufacturers as set out in the Medi-Span or similar third party database used by HNL. The Food and Drug Administration must approve the Generic Drug as meeting the same standards of safety, purity, strength and effectiveness as the Brand Name Drug.

Group is the business organization (usually an employer or trust) to which HNL has issued the Policy to provide the benefits of this Plan.

Health Net Life Insurance Company (HNL) is a life and disability insurance company regulated by the California Department of Insurance. The term "We," "Our" or "Us" when they appear in this *Certificate* refer to HNL.

Health Net PPO is the Preferred Provider Organization (PPO) plan described in this *Certificate*, which allows You to obtain medical benefits from either a network of Preferred Providers with whom HNL has contracted to provide services at the Contracted Rate; or else any Out-of-Network Provider. Health Net PPO is underwritten by HNL.

Health Net Recommended Drug List (also known as Recommended Drug List or the List) is a list of the Prescription Drugs that are covered by this Plan. It is prepared and updated by HNL and distributed to Covered Persons, Member Physicians and Participating Pharmacies and posted on the HNL website at www.healthnet.com under the pharmacy information. Some Drugs in the Recommended Drug List require Prior Authorization from HNL in order to be covered.

Home Health Care Agency is an organization licensed by the state in which it is located and has an agreement in force for rendering Home Health Care Services under the terms and conditions of this *Certificate* and certified by Medicare.

Home Health Care Services are services, including skilled nursing services, provided by a licensed Home Health Care Agency to a Covered Person in his or her place of residence that is prescribed by the Covered Person's attending Physician as part of a written plan. Home Health Care Services are covered if the Covered Person is homebound, under the care of a contracting physician, and requires Medically Necessary skilled nursing services, physical, speech, occupational therapy, or respiratory therapy or medical social services. Only Intermittent Skilled Nursing Services (not to exceed 4 hours a day) are covered benefits under this plan. Private Duty Nursing or shift care (including any portion of shift care services) is not covered under this plan. See also "Intermittent Skilled Nursing Services" and "Private Duty Nursing."

Hospice is a facility or program that provides a caring environment for meeting the physical and emotional needs of the terminally ill. The Hospice and its employees must be licensed according to applicable state and local laws and certified by Medicare.

Hospice Care is care that is designed to provide medical and supporting care to the terminally ill and their families. Hospice Care is designed to be provided primarily in Your home.

Hospital is a legally operated facility licensed by the state as an acute care Hospital and approved either by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by Medicare.

Intermittent Skilled Nursing Services are services requiring the skilled services of a registered nurse or LVN, which do not exceed 4 hours in every 24 hours.

Investigational approaches to treatment are those that have progressed to limited use on humans, but which are not widely accepted as proven and effective procedures within the organized medical community. HNL will decide whether a service or supply is considered Investigational.

Level I Drugs are Prescription Drugs listed in the Health Net Recommended Drug List that are primarily Generic Drugs and are not excluded or limited from coverage.

Level II Drugs are Prescription Drugs listed in the Health Net Recommended Drug List that are primarily Brand Name Drugs and are not excluded or limited from coverage.

Level III Drugs are Prescription Drugs that are not listed in the Health Net Recommended Drug List or listed as Level III Drugs in the Recommended Drug List and are not excluded or limited from coverage. Some Level III Drugs require Prior Authorization from HNL in order to be covered.

Maintenance Drugs are Prescription Drugs taken continuously to manage chronic or long term conditions where Covered Persons respond positively to a drug treatment plan with a specific medication at a constant dosage requirement.

Maximum Allowable Amount is the amount on which HNL bases its reimbursement for Covered Services and Supplies provided by an Out-of-Network Provider, which may be less than the amount billed for those services and supplies. HNL calculates Maximum Allowable Amount as the lesser of the amount billed by the Out-of-

Network Provider or the amount determined as set forth herein. Maximum Allowable Amount is not the amount that HNL pays for a Covered Service; the actual payment will be reduced by applicable Coinsurance, Copayments, Deductibles and other applicable amounts set forth in this *Certificate*.

- Maximum Allowable Amount for physician services is determined by applying a designated percentile from the database of physician charges from the Ingenix MDR Payment System (MDR) or a similar type of database of physician charges.
- For hospital services, Maximum Allowable Amount is calculated using a method developed by Viant, Inc., a data service that applies a hospital profit margin factor for hospitals, to the estimated costs of the services rendered by the Out-of-Network hospital or a similar type of hospital data service.
- For other types of services, Maximum Allowable Amount is determined by applying a designated percentile from the database of applicable professional or ancillary provider charges from the MDR or a similar type of database of applicable professional or ancillary provider charges. Payments to providers other than physicians may be reduced based upon their licensed scope of practice.
- In the event the applicable service or database does not include an amount for the service or supply provided, Maximum Allowable Amount shall be deemed to be 75% of the amount normally charged by the provider for the same services or supplies. The Maximum Allowable Amount determined under the databases described above may be more or less than 75% of the amount normally charged by the provider for the same services or supplies.
- The Maximum Allowable Amount may also be subject to other limitations on Covered Expenses. See "Schedule of Benefits," "Plan Benefits" and "General Limitations and Exclusions" sections for specific benefit limitations, maximums, pre-certification requirements and payment policies that limit the amount HNL pays for certain Covered Services and Supplies. HNL uses guidelines of Medicare and its contractors, other governmental regulatory bodies and nationally recognized medical societies and organizations to assist in its determination as to which services and procedures are eligible for reimbursement.

From time to time, HNL also contracts with vendors that have contracted fee arrangements with providers ("Third Party Networks"). In the event HNL contracts with a Third Party Network that has a contract with the Out-of-Network Provider, HNL may, at its option, use the rate agreed to by the Third Party Network as the Maximum Allowable Amount, in which case You will not be responsible for the difference between the Maximum Allowable Amount and the billed charges. You will be responsible for any applicable Deductible, Copayment and/or Coinsurance at the Out-of-Network level.

In addition, HNL may, at its option, refer a claim for Out-of-Network Services to a fee negotiation service to negotiate the Maximum Allowable Amount for the service or supply provided directly with the Out-of-Network Provider. In that situation, if the Out-of-Network Provider agrees to a negotiated Maximum Allowable Amount, You will not be responsible for the difference between the Maximum Allowable Amount and the billed charges. You will be responsible for any applicable Deductible, Copayment and/or Coinsurance at the Out-of-Network level.

In the event that the billed charges for the Out-of-Network Provider are more than the Maximum Allowable Amount, You are responsible for any amounts charged in excess of the Maximum Allowable Amount, except where the Out-of-Network Provider's fee is determined by reference to a Third Party Network agreement or the Out-of-Network Provider agrees to a negotiated Maximum Allowable Amount.

Please note that whenever You obtain Covered Services and Supplies from an Out-of-Network Provider, You are responsible for applicable Deductibles, Copayments and Coinsurance.

For more information on the determination of Maximum Allowable Amount, or for information, services and tools to help You further understand Your potential financial responsibilities for Covered Out-of-Network Services and Supplies please log on to www.healthnet.com or contact HNL Customer Service at the number on Your member identification card.

Maximum Allowable Cost for any Prescription Drug is the maximum charge HNL will allow for Generic Drugs or for Brand Name Drugs which have a generic equivalent. A list of Maximum Allowable Costs is maintained, and may be revised periodically, by HNL.

Medical Child Support Order is a court judgment or order that, according to state or federal law, requires group health plans that are affected by that law to provide coverage to a child or children who is the subject of such an order. HNL will honor such orders.

Medically Necessary (or Medical Necessity) means health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient, Physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Medicare is the name commonly used to describe Health Insurance Benefits for the Aged and Disabled provided under Public Law 89-97 as amended to date or as later amended.

Mental Disorders are a nervous or mental condition that meets all of the following conditions:

- It is a clinically significant behavioral or psychological syndrome or pattern;
- It is associated with a painful symptom, such as distress;
- It impairs a patient's ability to function in one or more major life activities; or
- It is a condition listed as an Axis I Disorder (excluding V Codes) in the most recent edition of the DSM by the American Psychiatric Association.

Neuro-Musculoskeletal Disorder is a misalignment of the skeletal structure, muscular weakness, osteopathic imbalance or any disorder related to the spinal cord, neck or joints.

Nonparticipating Pharmacy is a facility not authorized by HNL to be a Participating Pharmacy.

Open Enrollment Period is a period of time each Calendar Year, during which individuals who are eligible for coverage in this Plan may enroll for the first time, or if You were enrolled previously, may add Your eligible dependents.

The Group decides the exact dates for the Open Enrollment Period.

Changes requested during the Open Enrollment Period become effective on the first day of the calendar month following the date the request is submitted, or on any date approved by Us.

Out-of-Network Providers are Physicians, Hospitals or other providers of health care who are not part of the Health Net PPO Preferred Provider Organization (PPO), except as noted under the definitions for "Bariatric Surgery Performance Center" and "Transplant Performance Center."

Out-of-Pocket Maximum is the maximum dollar amount of Copayments and Coinsurance for which You must pay during a Calendar Year. After that maximum is reached, a different Coinsurance applies to further Covered Expenses incurred during the remainder of that Calendar Year, as shown in the "Schedule of Benefits" section. Certain expenses, as described in the "Schedule of Benefits" section, will not be applied to the Out-of-Pocket Maximum, nor will the different Coinsurance apply to these expenses after the Out-of-Pocket Maximum is reached.

Outpatient Surgical Center is a facility other than a medical or dental office, whose main function is performing surgical procedures on an outpatient basis. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services.

Pain means a sensation of hurting or strong discomfort in some part of the body caused by an injury, illness, disease, functional disorder or condition.

Participating Pharmacy is a facility authorized by HNL to dispense Prescription Drugs to persons eligible for benefits under the terms of this *Certificate*. A list of Participating Pharmacies and a detailed explanation of how the program operates has been provided or will be provided by HNL.

Physician means:

- A doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or
- One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for whom benefits are specified in this *Certificate*, and when benefits would be payable if the services were provided by a Physician as defined above:

Dentist (D.D.S.)
Optometrist (O.D.)
Dispensing optician
Podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
Psychologist
Chiropractor (D.C.)
Nurse midwife
Nurse Practitioner
Physician Assistant
Clinical social worker (M.S.W. or L.C.S.W.)
Marriage, family and child counselor (M.F.C.C.)
Physical therapist (P.T. or R.P.T.)
Speech pathologist
Audiologist
Occupational therapist (O.T.R.)
Psychiatric mental health nurse
Respiratory care practitioner
Acupuncturist (A.C.)

Preferred Provider Organization is a health care provider arrangement whereby HNL contracts with a group of Physicians or other medical care providers who have contracted to furnish services at the rate known as the Contracted Rate.

Preferred Providers are Physicians, Hospitals or other providers of health care who have a written agreement with HNL to participate in the Preferred Provider Organization (PPO) network and have agreed to provide You with Covered Services and Supplies at a contracted rate (the Contracted Rate), except as noted under the definitions for "Bariatric Surgery Performance Center" and "Transplant Performance Center." You must pay any Deductible(s), Copayment or Coinsurance required, but are not responsible for any amount charged in excess of the Contracted Rate. Preferred Providers are listed in the Preferred Provider Directory given to You upon enrollment and periodically updated. To insure the participation by a Preferred Provider, please contact the Member Services Department at the telephone number on Your HNL ID Card before services are received.

Prescription Drug is a drug or medicine that can be obtained only by a Prescription Drug Order. All Prescription Drugs are required to be labeled "Caution, Federal Law Prohibits Dispensing Without a Prescription." An exception is insulin and other diabetic supplies, which are considered to be covered Prescription Drugs.

Prescription Drug Covered Expenses are the maximum charges HNL will allow for each Prescription Drug Order. The amount of Prescription Drug Covered Expenses varies by whether a Participating or Nonparticipating Pharmacy dispenses the order. It is not necessarily the amount the pharmacy will bill. Any expense incurred which exceeds the following amounts is not a Prescription Drug Covered Expense: (a) for Prescription Drug Orders dispensed from a Participating Pharmacy, or through the mail service program, the Prescription Drug Allowable Charge; (b) for Prescription Drug Orders dispensed by a Nonparticipating Pharmacy, the lesser of the Maximum Allowable Cost or the Average Wholesale Price.

Prescription Drug Allowable Charge is the charge that Participating Pharmacies and the mail service program have agreed to charge Covered Persons, based on a contract between HNL and such provider.

Prescription Drug Order is a written or verbal order or refill notice for a specific drug, strength and dosage form (such as a tablet, liquid, syrup or capsule) directly related to the treatment of an illness or injury and which is issued by the attending Physician within the scope of his or her professional license.

Prior Authorization is HNL's approval process for certain Level I, Level II and Level III Drugs. Physicians must obtain HNL's Prior Authorization before certain Level I, Level II and Level III Drugs will be covered.

Private Duty Nursing means continuous nursing services provided by a licensed nurse (RN, LVN or LPN) for a patient who requires more care than is normally available during a home health care visit or is normally and routinely provided by the nursing staff of a Hospital or Skilled Nursing Facility. Private Duty Nursing includes nursing services (including intermittent services separated in time, such as 2 hours in the morning and 2 hours in the evening) that exceeds a total of four hours in any 24-hour period. Private Duty Nursing may be provided in an inpatient or outpatient setting, or in a non-institutional setting, such as at home or at school. Private Duty Nursing may also be referred to as "shift care" and includes any portion of shift care services.

Residential Treatment Center is a twenty-four hour, structured and supervised group living environment for children, adolescents or adults where psychiatric, medical and psychosocial evaluation can take place, and distinct and individualized psychotherapeutic interventions can be offered to improve their level of functioning in the community. HNL requires that all contracted Residential Treatment Centers must be appropriately licensed by their state in order to provide residential treatment services.

Serious Emotional Disturbances Of A Child is when a child under the age of 18 has one or more Mental Disorders identified in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, other than a primary substance use disorder or a developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. In addition, the child must meet one or more of the following:

- As a result of the Mental Disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships or ability to function in the community; and either (i) the child is at risk of removal from home or already has been removed from the home or (ii) the Mental Disorder and impairment have been present for more than six months or are likely to continue for more than one year;
- The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a Mental Disorder; and/or
- The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Severe Mental Illness is a category of Mental Disorder which includes schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorders, pervasive developmental disorder (including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified to include Atypical Autism, in accordance with the most recent edition of the *Diagnostic and Statistical Manual for Mental Disorders*), autism, anorexia nervosa and bulimia nervosa.

Skilled Nursing Facility is an institution that is licensed by the appropriate state and local authorities to provide skilled nursing services. In addition, Medicare must approve the facility as a participating Skilled Nursing Facility.

Special Care Units are special areas of a Hospital which have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

Specialty Drugs are Prescription Drugs listed in the Health Net Recommended Drug List. These drugs include self-administered injectables and other drugs that have significantly higher cost than traditional pharmacy benefit drugs. Specialty Drugs require Prior Authorization from HNL and must be dispensed through the Specialty Pharmacy Vendor to be covered.

Specialty Pharmacy Vendor is a pharmacy contracted with HNL specifically to provide injectable medications (including needles and syringes, when appropriate, to administer such drugs).

Transplant Performance Center is a provider in HNL's designated network in California for solid organ, tissue and stem cell transplants and transplant-related services, including evaluation and follow-up care. For purposes of determining coverage for transplants and transplant-related services, HNL's network of Transplant Performance Centers includes any providers in HNL's designated supplemental resource network. Preferred Providers that are not designated as part of HNL's network of Transplant Performance Centers are considered Out-of-Network Providers for purposes of determining coverage and benefits for transplants and transplant-related services.

Certificate Amendments

LIST OF AMENDMENTS

BY ORDER OF STATE LISTED IN THIS SECTION

ALASKA
ARKANSAS
FLORIDA
IDAHO
INDIANA
MAINE
MARYLAND
MASSACHUSETTS
MISSISSIPPI
MONTANA
NEW HAMPSHIRE
NEW YORK
NORTH DAKOTA
OREGON
PENNSYLVANIA
SOUTH CAROLINA
SOUTH DAKOTA
TEXAS
WEST VIRGINIA
WISCONSIN

(Attach this Certificate Amendment to Your Certificate of Insurance)

CERTIFICATE AMENDMENT

to the Certificate of Insurance

For: Covered Persons residing in Alaska

Your Certificate is amended to conform to the requirements of the state of Alaska.

Any limitations and exclusions contained in Your Certificate which are in conflict with these requirements are hereby amended to comply with the minimum state requirements.

Benefits payable under this Amendment are reduced to the extent that benefits are payable for the same expenses under the Medical Benefit or Outpatient Prescription Drug Benefit, if applicable.

The provisions on the following pages form part of this Certificate Amendment.

All other terms and conditions shown in Your Certificate will continue to apply.

HEALTH NET LIFE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read "S. Sell", written in a cursive style.

Steven Sell

President

1. The SCHEDULE OF BENEFITS section of Your Certificate is amended to delete the subsection entitled “Treatment for Chemical Dependency” and *substitute* the following:

Treatment for Chemical Dependency

Coverage shall be provided on the same basis as any other Illness, subject to a maximum benefit of \$12,715 during any 24 month period, and subject to a lifetime maximum amount of \$24,425.

Maximum benefits will be adjusted by the director of the Alaska Department of Insurance every three years to correspond with the change in the medical care component of the consumer price index for all urban consumers for the Anchorage Metropolitan Area compiled by the Bureau of Labor Statistics, United States Department of Labor.

2. The **Medical Benefits** section of Your Certificate is revised to add the following benefits under **Preventive Care for Adults**:

- (a) **Mammography Coverage**

Coverage for mammography includes coverage for a mammogram for a woman of any age if the Covered Person has breast cancer or whose parent or sibling has a history of breast cancer, upon referral by a Physician.

- (b) **Colorectal Cancer Screening Examination and Laboratory Tests**

Coverage is provided for an insured 50 years of age or older or less than age 50 with a high risk for colorectal cancer.

Coverage is provided for colorectal cancer examinations and laboratory tests specified in American Cancer Society guidelines for colorectal cancer screening of asymptomatic individuals. Coverage is also provided for all colorectal screening examinations and tests that are administered at a frequency identified in the American Cancer Society guidelines for colorectal cancer.

An individual is considered to be at high risk for colorectal cancer if the individual has:

- A family medical history of colorectal cancer;
- A prior occurrence of cancer or precursor neoplastic polyps;
- A history of chronic digestive disease condition including inflammatory bowel disease, Crohn’s disease or ulcerative colitis;
- The presence of any appropriate recognized gene markers for colorectal cancer; or
- Other predisposing factors.

- (c) **Newborn and Infant Hearing Screening**

Coverage is provided for a newborn or infant screening within 30 days after the Dependent Child’s birth. If the initial screening determines that the child may have a hearing impairment, a conformity hearing diagnostic evaluation will be covered.

(Attach this Certificate Amendment to Your Certificate of Insurance)

CERTIFICATE AMENDMENT

to the Certificate of Insurance

For: Covered Persons residing in Arkansas

Your Certificate of Insurance is amended to conform to the requirements of the state of Arkansas.

Any limitations and exclusions contained in Your Certificate of Insurance which are in conflict with these requirements are hereby amended to comply with the minimum state requirements.

Benefits payable under this Amendment are reduced to the extent that benefits are payable for the same expenses under the Medical Benefit or Outpatient Prescription Drug Benefit, if applicable.

The provisions on the following pages form part of this Certificate Amendment.

All other terms and conditions shown in Your Certificate of Insurance will continue to apply.

HEALTH NET LIFE INSURANCE COMPANY



Steven Sell

President

1. The **Additional Services and Supplies** subsection of the Medical Benefit section of Your Certificate of Insurance is revised to delete “Diabetic Equipment” and to *substitute* the following:

Diabetes Equipment, Supplies and Appliances

Coverage is provided for the equipment, supplies and services listed below prescribed by a Covered Person’s Physician licensed under Ark. Code Ann. ss 17-95-201, et seq., which are Medically Necessary for the treatment of diabetes mellitus, including and not limited to Type 1, Type 2, and gestational diabetes.

- (1) Blood glucose monitors, which include all commercially available blood glucose monitors designed for patient use and for persons who have been diagnosed with diabetes;
 - (2) Blood glucose monitors for the legally blind, which include all commercially available blood glucose monitors designed for patient use with adaptive devices and for persons who are legally blind and have been diagnosed with diabetes;
 - (3) Test strips for glucose monitors, which include all test strips approved by the Federal Food and Drug Administration, glucose control solutions, lancet devices, and lancets for monitoring glycemic control;
 - (4) Visual reading and urine testing strips, which include visual reading strips for glucose, urine testing strips for ketones, or urine test strips for both glucose and ketones. Urine test strips for glucose only are not acceptable as the sole method of monitoring;
 - (5) Insulin, which includes all commercially available insulin preparations including insulin analog preparations available in either vial or cartridge;
 - (6) Injection aids, which include devices used to assist with insulin injection;
 - (7) Syringes, which include insulin syringes, pen-like insulin injection devices, pen needles for pen-like insulin injection devices;
 - (8) Insulin pumps as prescribed by the Physician and appurtenances thereto, which include insulin infusion pumps and supplies such as skin preparations, adhesive supplies, infusion sets, cartridges, batteries and other disposable supplies needed to maintain insulin pump therapy. These include durable and disposable devices used to assist in the injection of insulin;
 - (9) Oral agents for controlling the blood sugar level, which are prescription drugs;
 - (10) Podiatric appliances for prevention of complications associated with diabetes, which include therapeutic molded or depth-inlay shoes, replacement inserts, preventive devices, and shoe modifications for prevention and treatment; and
 - (11) Glucagon Emergency Kits and injectable glucagon.
2. The following benefits are added to the **Additional Services and Supplies** section of the Medical Benefit section of Your Certificate. These benefits are in addition to any coverage otherwise payable under the Medical Benefit.

Newborn Infant Coverage

Coverage is provided for illness, Injury, congenital defects, premature birth, and tests for hypothyroidism, phenylketonuria and galactosemia, and in the case of non-Caucasian newborn infants, tests for sickle-cell anemia, as well as any testing of newborn infants mandated by Arkansas

law, and also includes coverage to pay for routine nursery care and pediatric charges for a well newborn child for up to five (5) full days in a Hospital nursery or until the mother is discharged from the Hospital following the birth of the child, whichever is the lesser period of time.

Notice must be given to HNL of any newborn children within 90 days of the birth, and pay any applicable premium required for Dependent coverage, if such premium is required under the terms of the plan.

In-Vitro Fertilization Coverage

Coverage is provided for in-vitro fertilization services performed at a medical facility, licensed or certified by the Arkansas Department of Health, those performed at a facility certified by the Arkansas Department of Health which conforms to the American College of Obstetricians and Gynecologists guidelines for in-vitro fertilization clinics or those performed at a facility certified by the Arkansas Department of Health which meets the American Fertility Society minimal standards for programs of in-vitro fertilization. Coverage will not exceed the maximum level established by the Arkansas State Insurance Commissioner.

Off-Label Prescription Drug Use

1. If coverage is provided under the Medical Benefit or the Outpatient Prescription Drug Benefit, if applicable, coverage will be provided for prescription drugs for a treatment for which the prescription drug has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific treatment for which it has been prescribed in one of the following established reference compendia:
 - a. the American Hospital Formulary Service Drug Information;
 - b. the United States Pharmacopeia Drug Information;or, it is recommended by a clinical study or review article in a major peer-reviewed professional journal.
2. The coverage required pursuant to this section:
 - a. Includes coverage for any Medically Necessary services to administer the drug to the Covered Person.
 - b. Does not include coverage for any:
 - drug which is deemed Experimental or if Investigational; or
 - use of a drug that is contraindicated by the Food and Drug Administration for the treatment for which it is prescribed.

Off-Label FDA Approved Cancer Drugs

If coverage is provided under the Medical Benefit or the Outpatient Prescription Drug Benefit, if applicable, coverage will be provided for prescription drugs for the treatment of cancer even if the prescription drug has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific type of cancer, if the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the following standard reference compendia, unless the use is identified as not indicated in one (1) or more of these standard reference compendia:

- a. The American Hospital Formulary Service Drug Information;
- b. The National Comprehensive Cancer Network Drugs and Biologics Compendium;

c. The Elsevier Gold Standard's Clinical Pharmacology; or

The drug has been recognized as safe and effective for treatment of that specific type of cancer in two (2) articles from medical literature that have not had their recognition of the drug's safety and effectiveness contradicted by clear and convincing evidence presented in another article from medical literature; or

Other authoritative compendia as identified by the Secretary of the United States Department of Health and Human Services or the commissioner may be used to provide coverage by Us at the Covered Person's discretion.

Coverage of a drug required above includes Medically Necessary services associated with the administration of the drug, provided that such services are covered under the Certificate of Insurance.

Prostate Cancer Screening

Coverage is provided for screening for the early detection of prostate cancer in men forty (40) years of age and older according to the National Comprehensive Cancer Network guidelines, as in effect on January 1, 2009.

The coverage for prostate cancer screening:

- a. is subject to Deductibles; and
- b. will not exceed the actual cost of the prostate cancer screening up to the maximum allowable cost per screening.

The prostate cancer screening must be performed by a qualified medical professional; and

The coverage will provide one (1) screening per year for any man forty (40) years of age or older according to the National Comprehensive Cancer Network guidelines, as in effect on January 1, 2009.

The coverage for prostate cancer screening does not diminish or limit diagnostic benefits otherwise allowable under the Certificate of Insurance.

If a medical practitioner recommends that a Covered Person undergo a prostate specific antigen blood test, coverage will not be denied on the ground that the Covered Person has already had a digital rectal examination and the examination result was negative.

Temporomandibular Joint Dysfunction (TMJ) and Functional Deformity Coverage

Coverage is provided for Medically Necessary surgical and non-surgical treatment of temporomandibular joint dysfunction by a Physician, including a dentist, professionally qualified by training and experience and for Medically Necessary surgery for the correction of functional deformities of maxilla and mandible.

Coverage for the nonsurgical treatment of temporomandibular joint dysfunction is limited to history and examination; radiographs, which must be diagnostic for temporomandibular joint dysfunction; splint therapy with necessary adjustments and diagnostic or therapeutic masticatory muscle and temporomandibular joint injections.

“Functional deformity” means a deformity of the bone or joint structure of the maxilla or mandible such that the normal character and essential function of such bone structure is impeded.

“Temporomandibular joint” means the connection of the mandible and the temporal bone through the articular disc surrounded by the joint capsule and associated ligaments and tendons.

“Temporomandibular joint dysfunction” means congenital or developed anomalies of the temporomandibular joint.

3. General Anesthesia In Conjunction with Dental Care

Coverage is provided for general anesthesia and associated Hospital or Ambulatory Surgical Facility charges in conjunction with dental care provided to a Covered Person insured if the provider treating the patient certifies that, because of the patient’s age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures and the patient is:

- A. a child under seven (7) years of age who is determined by two (2) dentists licensed under the Arkansas Dental Practice Act, s 17-82-101 et seq., to require, without delay, necessary dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition;
- B. a person with a diagnosed serious mental or physical condition; or
- C. a person with a significant behavioral problem as determined by the Covered Person’s physician as licensed under the Arkansas Medical Practices Act, ss 17-95-201 - 17-95-207, 17-95-301 – 17-95-305, and 17-95-401 – 17-95-411.

If a Covered Person is covered under both a health benefit plan that provides dental benefits and a health benefit plan that provides medical benefits, the health benefit plan that includes dental benefits is the primary payer and the health benefits plan that provides medical benefits is the secondary payer.

Coverage is subject to Certification requirements shown in Your Certificate of Insurance.

(Attach this Certificate Amendment to Your Certificate of Insurance)

CERTIFICATE AMENDMENT

to the Certificate of Insurance

For: Covered Persons residing in Florida

THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED PRIMARILY BY THE LAW OF A STATE OTHER THAN FLORIDA.

Your Certificate of Insurance is amended to conform to the requirements of the state of Florida.

Any limitations and exclusions contained in Your Certificate of Insurance which are in conflict with these requirements are hereby amended to comply with the minimum state requirements.

Benefits payable under this Amendment are reduced to the extent that benefits are payable for the same expenses under the Medical Benefit or Outpatient Prescription Drug Benefit, if applicable.

The provisions on the following pages form part of this Certificate Amendment.

All other terms and conditions shown in Your Certificate of Insurance will continue to apply.

HEALTH NET LIFE INSURANCE COMPANY



Steven Sell

President

1. The **Additional Services and Supplies** subsection of the Medical Benefit section of Your Certificate of Insurance is revised to delete **Mammography** from **Preventive Care for Adults** and *substitute* the following:

Breast Cancer Screening and Services

Coverage is provided as follows:

Mammograms

- A. one baseline mammogram provided to women who are between the ages of 35 and 39;
- B. one mammogram every two years provided to women who are between the ages of 40 and 49, or more frequently if recommended by a Physician; and
- C. one mammogram every year provided to women who are age 50 or older.
- D. Mammograms for women considered “at risk”, or as recommended by a Physician. As used here, “at risk” means a woman who has:
 - a personal history of breast cancer;
 - a personal history of biopsy-proven benign breast disease;
 - a mother, sister, or daughter who has had cancer; or
 - not given birth prior to age 30.

Mammogram screening means the x-ray examination for the breast using equipment dedicated specifically for mammography, including but not limited to the x-ray tube, filter, compression device, screen, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast and two views for each breast, as well as the Physician’s interpretation of such procedure.

Diagnostic Services

Procedures performed on an inpatient or outpatient basis which are intended to aid in the diagnosis of breast cancer. Such services include, but are not limited to, surgical breast biopsy and pathologic examination and interpretation.

Breast Cancer Outpatient Treatment

Procedures intended to treat cancer of the breast when received on an outpatient basis including, but not limited to, surgery, radiation therapy, chemotherapy, hormonal therapy, and related medical follow-up services.

Breast Cancer Rehabilitative Services

Procedures intended to improve the results of breast cancer treatment when received on an inpatient or outpatient basis. Such services include, but are not limited to, physical therapy, and psychological and social support services.

Reconstructive Breast Surgery

Reconstructive breast surgery following a mastectomy which resulted from disease, illness, or Injury. Also included are all stages of one reconstructive breast reduction, augmentation, mammoplasty, or mastopexy on the non-diseased breast to make it equal in size with the diseased breast after reconstructive surgery on the diseased breast has been performed.

Prostheses and Post-Mastectomy Care

At least two post-operative Prostheses made necessary by a mastectomy and post-mastectomy care as determined by the attending Physician.

2. The following benefits are added to the **Additional Services and Supplies** section of Your Certificate. These benefits are in addition to any coverage otherwise payable under the Medical Benefit.

Autism Spectrum Disorder

Coverage is provided for dependent children under age 18, and for dependent children age 18 or over who have been diagnosed as having a developmental disability at age 8 or under.

Coverage includes speech therapy, occupational therapy, physical therapy and applied behavioral analysis for treatment of autistic disorder, Asperger's syndrome, and pervasive developmental disorder.

Coverage must be provided by an individual certified by the state of Florida to provide such services.

Coverage is subject to a Calendar Year maximum of \$36,000 and a lifetime maximum of \$200,000.

Treatment of Cleft Lip and Cleft Palate

Coverage is provided for children under age 18 for treatment of cleft lip, cleft palate, or both. Coverage includes medical, dental, speech therapy, audiology, and nutrition services if such services are prescribed by the treating Physician or surgeon and such Physician or surgeon certifies that such services are Medically Necessary and consequent to treatment of the cleft lip or cleft palate.

Osteoporosis Coverage

Coverage is provided for the Medically Necessary diagnosis and treatment of osteoporosis for high-risk individuals, including, but not limited to, estrogen-deficient individuals who are at clinical risk for osteoporosis, individuals who have vertebral abnormalities, individuals who are receiving long-term glucocorticoid (steroid) therapy, individuals who have primary hyperparathyroidism and individuals who have a family history of osteoporosis.

3. The ELIGIBILITY, ENROLLMENT AND TERMINATION section of Your Certificate is revised to delete the following from the Conversion Coverage provision:

You must request and complete an application form and send it to HNL within 31 days of the last day of coverage.

and *substitute* the following:

You must request and complete an application form and send it to HNL within 63 days of the last day of coverage.

4. The **Age Limit for Children** subsection of the ELIGIBILITY, ENROLLMENT AND TERMINATION section of Your Certificate is *replaced* with the following:

Age Limit for Children

A child who is dependent upon You for support and who is living in Your household or is a full-time or part-time student, is eligible until the end of the Calendar Year in which the child attains age 25 (the limiting age): (i) who is not an employee eligible for coverage under a group health

plan offered by the child's employer for which the child's premium contribution amount is no greater than the premium amount for coverage as a Dependent under a parent's individual or group health plan; (ii) who is not a named subscriber, insured, enrollee, or covered individual under any other individual health insurance coverage, group health plan, government plan, church plan, or group health insurance coverage; (iii) who is not entitled to Social Security benefits under § 42 U.S.C. 1395, et seq.; and (iv) for whom the insured parent has requested coverage. Such child may remain eligible for coverage until the end of the Calendar Year in which he or she reaches age 30 if such child is unmarried and does not have a dependent of his or her own, and is a resident of Florida or a full-time or part-time student.

CERTIFICATE AMENDMENT

to the Certificate of Insurance

For: Covered Persons residing in Idaho

Your Certificate of Insurance is amended to conform to the requirements of the state of Idaho.

Any limitations and exclusions contained in Your Certificate of Insurance which are in conflict with these requirements are hereby amended to comply with the minimum state requirements.

Benefits payable under this Amendment are reduced to the extent that benefits are payable for the same expenses under the Medical Benefit or Outpatient Prescription Drug Benefit, if applicable.

The provisions on the following pages form part of this Certificate Amendment.

All other terms and conditions shown in Your Certificate of Insurance will continue to apply.

HEALTH NET LIFE INSURANCE COMPANY



Steven Sell

President

The **Age Limit for Children** subsection of the ELIGIBILITY, ENROLLMENT AND TERMINATION section of Your Certificate is replaced with the following:

Age Limit for Children

A child who is dependent upon You, the parent for more than 50% of his or her financial support, and who is under age 25.

CERTIFICATE AMENDMENT

to the Certificate of Insurance

For: Covered Persons residing in Indiana

Your Certificate of Insurance is amended to conform to the requirements of the state of Indiana.

Any limitations and exclusions contained in Your Certificate of Insurance which are in conflict with these requirements are hereby amended to comply with the minimum state requirements.

Benefits payable under this Amendment are reduced to the extent that benefits are payable for the same expenses under the Medical Benefit or Outpatient Prescription Drug Benefit, if applicable.

The provisions on the following pages form part of this Certificate Amendment.

All other terms and conditions shown in Your Certificate of Insurance will continue to apply.

HEALTH NET LIFE INSURANCE COMPANY



Steven Sell

President

1. The **Additional Services and Supplies** subsection of the Medical Benefit section of Your Certificate of Insurance is revised to delete **Mammography** from **Preventive Care for Adults**, and *substitute* with the following:

Mammography in screening purposes for detection of breast cancer, performed by a mammography services provider accredited by the American College of Radiology and who meets equivalent guidelines established by the state department of Indiana or is certified by the Federal Department of Health and Human Services for participation in the Medicare program, using equipment designed by the manufacturer for and dedicated specifically to mammography.

Coverage includes the following:

- a. If the Covered Person is at least thirty-five (35) but less than forty (40) years of age, coverage for at least one (1) baseline breast cancer screening mammography performed upon the Covered Person before she becomes forty (40) years of age.
- b. If the Covered Person is:
 - less than forty (40) years of age; and
 - a woman at risk;one (1) breast cancer screening mammography performed upon the Covered Person every year.
- c. If the Covered Person is at least forty (40) years of age, one (1) breast cancer screening mammography performed upon the Covered Person every year.
- d. Any additional mammography views that are required for proper evaluation.
- e. Ultrasound services, if determined Medically Necessary by the Physician treating the Covered Person.

“Woman at risk” means a woman who meets at least one (1) of the following descriptions:

1. **A woman who has a personal history of breast cancer.**
2. A woman who has a personal history of breast disease that was proven benign by biopsy.
3. A woman whose mother, sister, or daughter has had breast cancer.
4. A woman who is at least thirty (30) years of age and has not given birth.

2. The following benefits are added to the **Additional Services and Supplies** section of Your Certificate. These benefits are in addition to any coverage otherwise payable under the Medical Benefit.

Treatment of Cleft Lip and Cleft Palate

Benefits are payable for a covered newborn Child born with a cleft lip, cleft palate, or both, including the following:

- a. oral and facial surgery, surgical management, and follow-up care by plastic surgeons and oral surgeons;
- b. prosthetic treatment such as obturators, speech appliances and feeding appliances;
- c. Medically Necessary orthodontic treatment;
- d. Medically Necessary prosthodontic treatment;
- e. habilitative speech therapy;
- f. otolaryngology treatment; and
- g. audiological assessments and treatment.

Benefits will not be payable under this section for dental or orthodontic treatment unrelated to the management of cleft lip and cleft palate.

Off-Label Prescription Drug Use

If coverage is provided for prescription drug charges under the Medical Benefit or the Outpatient Prescription Drug Benefit, if applicable, coverage will be provided for prescription drugs for a treatment for which the prescription drug has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific treatment for which it has been prescribed in at least one standard reference compendia; or

The drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in either the United States or Great Britain.

Coverage for the Treatment of Pervasive Developmental Disorder

Benefits are payable for the treatment of pervasive developmental disorder on the same basis as any other illness covered under the plan.

“Pervasive developmental disorder” means a neurological condition, including Asperger’s syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Prosthetic and Orthotic Devices

- (1) Coverage is provided for prosthetic and orthotic devices including repairs or replacements that are Medically Necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that are not solely for comfort or convenience. The coverage includes all services and supplies Medically Necessary for the effective use of a prosthetic or orthotic device, including formulating its design, fabrication, material and component selection, measurements, fittings, static and dynamic alignments, and instructing the patient in the use of the device.
- (2) As used herein:
 - (a) “Orthotic device” means a Medically Necessary custom fabricated brace or support that is designed as a component of a prosthetic device.
 - (b) “Prosthetic device” means an artificial leg or arm.
- (3) The coverage for prosthetic and orthotic devices will be paid on the same basis as any other illness.
- (4) The coverage includes any repair or replacement of a prosthetic or orthotic device that is determined Medically Necessary by a Covered Person’s Physician to restore or maintain the ability to complete activities or daily living or essential job-related activities and that is not solely for comfort or convenience.

Oral Cancer Chemotherapy Coverage

Coverage for orally administered chemotherapy, provided under Your Certificate of Insurance will be payable on the same basis as coverage provided for cancer chemotherapy that is administered intravenously or by injection.

Coverage for Clinical Trials

Coverage is provided for patient routine care costs pursuant to qualified clinical trials to the same extent as they would be covered and reimbursed if the patient did not receive care in a qualified clinical trial. "Routine care cost" means the cost of Medically Necessary services related to the care method that is under evaluation in a clinical trial. The term does not include the following:

1. The health care service, item, or investigational drug that is the subject of the clinical trial.
2. Any treatment modality that is not part of the usual and customary standard of care required to administer or support the health care service, item, or investigational drug that is subject of the clinical trial.
3. Any health care service, item, or drug provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient.
4. An investigational drug or device that has not been approved for market by the federal Food and Drug Administration.
5. Transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that are associated with travel to or from a facility where a clinical trial is conducted.
6. A service, item, or drug that is provided by a clinical trial sponsor free of charge for any new patient.
7. A service, item, or drug that is eligible for reimbursement from a source other than an enrollee's individual contract or group contract, including the sponsor of the clinical trial.

"A clinical trial" means a Phase I, II, III, or IV research study:

1. that is conducted:
 - a. using a particular care method to prevent, diagnose, or treat a cancer for which:
 - i. there is no clearly superior, noninvestigational alternative care method; and
 - ii. available clinical or preclinical data provides a reasonable basis from which to believe that the care method used in the research study is at least as effective as any noninvestigational alternative care method;
 - b. in a facility where personnel providing the care method to be followed in the research study have:
 - i. received training in providing the care method;
 - ii. expertise in providing the type of care required for the research study; and
 - iii. experience providing the type of care required for the research study to a sufficient volume of patients to maintain expertise; and
 - c. to scientifically determine the best care method to prevent, diagnose, or treat the cancer; and
2. that is approved or funded by one (1) of the following:
 - a. A National Institutes of Health institute.
 - b. A cooperative group of research facilities that has an established peer review program that is approved by a National Institutes of Health institute or center.
 - c. The federal Food and Drug Administration.
 - d. The United States Department of Veterans Affairs.
 - e. The United States Department of Defense.
 - f. The institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institutes of Health Office for Protection from Research Risks as provided in 45 CFR 46.103.
 - g. A research entity that meets eligibility criteria for a support grant from a National Institutes of Health center.

Coverage for clinical trials is not covered if provided by an Out-of-Network provider.

CERTIFICATE AMENDMENT

to the Certificate of Insurance

For: Covered Persons residing in Maine

Your Certificate of Insurance is amended to conform to the requirements of the state of Maine.

Any limitations and exclusions contained in Your Certificate of Insurance which are in conflict with these requirements are hereby amended to comply with the minimum state requirements.

Benefits payable under this Amendment are reduced to the extent that benefits are payable for the same expenses under the Medical Benefit or Outpatient Prescription Drug Benefit, if applicable.

The provisions on the following pages form part of this Certificate Amendment.

All other terms and conditions shown in Your Certificate of Insurance will continue to apply.

HEALTH NET LIFE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read "S. Sell", is positioned above the printed name and title.

Steven Sell

President

1. The **Treatment of Non-Severe Mental Disorders** and **Treatment for Chemical Dependency** sections of the SCHEDULE OF BENEFITS of Your Certificate are deleted and *replaced* with the following:

Mental Disorders

Coverage shall be provided on the same basis as any other illness.

Alcoholism and Drug Dependency (Chemical Dependency)

Number of days Inpatient Hospital Services or residential treatment facility care per Calendar Year..... 30

For each inpatient or outpatient Physician visit \$25

Number of Physician's visits during a Calendar Year 50

Note: The maximum amount of Covered Expenses for each day of Hospital or residential treatment facility care (including residential care for drug dependency) is \$175.

2. The **Age Limit for Children** subsection of the ELIGIBILITY, ENROLLMENT AND TERMINATION section is revised to add the following provision.

If a full-time student ceases to remain enrolled in school due to a mental or physical illness or an accidental illness or injury, coverage will continue until he or she reaches the limiting age for students. In order to continue the coverage, the student must provide written documentation from a health care provider and the student's school that the student is no longer enrolled in school on a full-time basis due to a mental or physical illness or accidental injury.

3. The Medical Benefit is revised to add the following benefit:

General Anesthesia In Conjunction with Dental Care

Coverage is provided for general anesthesia and associated Hospital or Ambulatory Surgical Center charges in conjunction with dental care provided to a Covered Person if such Covered Person is:

1. An individual, includes an infant, exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, can not be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result;
2. An individual demonstrating dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy;
3. Extremely uncooperative, fearful, anxious or uncommunicative children or adolescent with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity; or
4. An individual who has sustained extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.

Coverage is not provided for the dental procedure itself, including, but not limited to, the professional fee of the dentist. Coverage for anesthesia and associated facility is subject to all other terms and conditions of the plan.

Payment will be reduced if Certification is not obtained.

4. The **Additional Services and Supplies** subsection of the Medical Benefit section of Your Certificate of Insurance is revised to delete Mammography under Preventive Care for Adults and to *substitute* the following:
 - (i) **Breast Cancer Screening.** Screening mammograms performed by providers that meet the standards established by the Maine Department of Human Services rules relating to radiation protection, performed annually for women 35 years of age and over.

Screening mammogram means a radiologic procedure that is provided to an asymptomatic woman for the purpose of early detection of breast cancer and that consists of 2 radiographic views per breast.

5. The following benefits are added to the **Additional Services and Supplies** section of Your Certificate. These benefits are in addition to any coverage otherwise payable under the Medical Benefit, or Outpatient Prescription Drug Benefit.

Coverage for Prescription Contraceptives

If Your Certificate of Insurance includes an Outpatient Prescription Drug Benefit, coverage will be provided under the Outpatient Drug Benefit for any type of drug or device for contraception which is lawfully prescribed or ordered and which has been approved by the Food and Drug Administration or for outpatient contraceptive services. This coverage does not include coverage for fertility treatment or for drugs or devices designed to terminate a pregnancy.

The Copayment required for such drug, device or service for contraception will not exceed the Copayment required for other Prescription Drugs covered under the Outpatient Prescription Drug Benefit.

Outpatient contraceptive services means consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of contraceptive methods to prevent an unintended pregnancy.

Modified Low-Protein Products

Coverage is provided for metabolic formula and special modified low-protein food products that have been prescribed by a licensed Physician for a person with an inborn error of metabolism.

Coverage is limited to charges for:

- a. Metabolic formula; and
- b. Up to \$3,000 per Calendar Year for special modified low-protein food products.

Special modified low-protein food product means food formulated to reduce the protein content to less than one gram of protein per serving and does not include foods naturally low in protein.

Medically Necessary Infant Formula

Coverage is provided for amino acid-based elemental infant formula for children 2 years of age and under as follows:

1. Determination of Medical Necessity. Coverage for amino acid-based elemental infant formula will be provided when a licensed Physician has submitted documentation that the amino acid-based elemental infant formula is Medically Necessary health care as defined in Maine Insur-

ance Code section 4301-A, subsection 10-A, that the amino acid-based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater and that other commercial infant formulas, including cow milk-based and soy milk-based formulas have been tried and have failed or are contraindicated. A licensed Physician may be required to confirm and document ongoing medical necessity at least annually.

2. Method of delivery. Coverage for amino acid-based elemental infant formula will be provided without regard to the method of delivery of the formula.
3. Required diagnosis. Coverage for amino acid-based elemental infant formula will be provided when a licensed Physician has diagnosed and through medical evaluation has documented one of the following conditions:
 - a. Symptomatic allergic colitis or proctitis;
 - b. Laboratory- or biopsy-proven allergic or eosinophilic gastroenteritis;
 - c. A history of anaphylaxis;
 - d. Gastroesophageal reflux disease that is nonresponsive to standard medical therapies;
 - e. Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a medical provider;
 - f. Cystic fibrosis; or
 - g. Malabsorption of cow milk-based or soy milk-based infant formula.

Off-Label Prescription Drug Use

1. If coverage is provided under the Medical Benefit or the Outpatient Prescription Drug Benefit, if applicable, coverage will be provided for prescription drugs for a treatment for which the prescription drug has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the treatment of cancer or HIV/AIDS in one of the following established reference compendia:
 - a. the American Hospital Formulary Service Drug Information or information provided by its successor organization;
 - b. the United States Pharmacopeia Drug Information or information provided by its successor organization;or, it is recommended by a clinical study or review article in major peer-reviewed medical literature.
2. The coverage required pursuant to this section:
 - a. Includes coverage for any Medically Necessary services to administer the drug to the Covered Person.
 - b. Does not include coverage for any:
 - drug which is deemed Experimental or if Investigational; or
 - use of a drug that is contraindicated by the Food and Drug Administration for the treatment for which it is prescribed.

Peer-reviewed medical literature means scientific studies published in at least 2 articles from major peer-reviewed medical journals that present data that supports the proposed off-label use as generally safe and effective.

Eye Care Services

Coverage for eye care services is provided as follows:

A Covered Person may receive eye care services from an eye care provider without Certification being required, for a maximum of 2 visits, one initial visit and one follow-up visit, for each occurrence requiring urgent care. In order to receive continuing benefits for treatment related to the initial visit, a Covered Person must receive Certification for any visit after the 2nd visit. Within 3 working days of the initial visit, the eye care provider shall send to Us a report containing the Covered Person's complaint, related history, examination results, initial diagnosis and recommendations for treatment. If the eye care provider does not send a report within 3 working days, HNL is not obligated to provide further benefits.

Coverage is not provided in connection with routine eye examinations.

Eye care provider means a participating provider who is an optometrist licensed to practice optometry pursuant to Maine Statutes Title 32, chapter 34-A, or an ophthalmologist licensed to practice medicine pursuant to Maine Statutes Title 32, chapter 48.

Eye care services means those urgent health care services related to the examination, diagnosis, treatment and management of conditions, illnesses and diseases of the eye and related structures that are provided to treat conditions, illnesses or diseases of the eye that if not treated within 24 hours present a serious risk of harm.

Breast Reduction Surgery and Symptomatic Varicose Vein Surgery

Coverage is provided for breast reduction surgery and symptomatic varicose vein surgery if determined to be Medically Necessary as defined in Maine Statute 4301-A, subsection 10-A.

6. Benefits for "Services for Non-Severe Mental Disorders" and "Chemical Dependency Services" under the Medical Benefit section of Your Certificate are deleted and *replaced* by the following:

Services for Mental Disorders. Covered Services rendered by a provider, for the Medically Necessary treatment of Mental Disorders, including autism as follows for a Covered Person suffering from a mental or nervous condition;

- a. inpatient care;
- b. Day treatment services; and
- c. Outpatient services.

Day treatment services includes psychoeducational, physiological, psychological and psychosocial concepts, techniques and processes to maintain or develop functional skills of clients, provided to individuals and groups for periods of more than 2 hours but less than 24 hours per day.

Inpatient services includes a range of physiological, psychological and other intervention concepts, techniques and processes in a community mental health psychiatric inpatient unit.

Hospital psychiatric unit or psychiatric Hospital licensed by the Maine Department of Human Services or accredited public hospital to restore psychosocial functioning sufficient to allow maintenance and support of the client in a less restrictive setting.

Outpatient services includes screening, evaluation, consultations, diagnosis and treatment involving use of psychoeducational, physiological, psychological and psychosocial evaluative and interventional concepts, techniques and processes provided to individuals and groups.

Person suffering from a mental or nervous condition means a person whose psychobiological processes are impaired severely enough to manifest problems in the areas of social, psychological or biological functioning. Such a person has a disorder of thought, mood, perception, orientation or memory which impairs judgment, behavior, capacity to recognize or ability to cope with the ordinary demands of life. The person manifests an impaired capacity to maintain acceptable levels of functioning in the areas of intellect, emotion or physical well-being.

Provider means individuals included in section 2835 Maine Statutes, and a licensed Physician with 3 years approved residency in psychiatry, an accredited public Hospital or psychiatric Hospital or a community agency licensed at the comprehensive service level by the Maine department of Mental Health, Mental Retardation and Substance Abuse Services. All agency or institutional providers named in this paragraph shall assure that services are supervised by a psychiatrist or licensed psychologist.

Alcoholism and Drug Dependency Treatment Services

Covered Services rendered by a provider for the Medically Necessary treatment of alcoholism and drug dependency as follows, for a Covered Person suffering from alcoholism or drug dependency:

- a. Residential treatment at a Hospital or free-standing residential treatment center which is licensed, certified or approved by the State of Maine; and
- b. Outpatient care rendered by the State of Maine licensed, certified or approved providers.

Treatment or confinement at any facility does not preclude further or additional treatment at any other eligible facility, provided that the benefit days used do not exceed the total number of benefit days shown in the SCHEDULE OF BENEFITS.

Outpatient care means care rendered by a state-licensed, approved or certified detoxification, residential treatment or outpatient program, or partial hospitalization program on a periodic basis, including, but not limited to, patient diagnosis, assessment and treatment, individual, family and group counseling and educational and support services.

Residential treatment means services at a facility that provides care 24 hours daily to one or more patients, including, but not limited to, the following services: Room and board; medical, nursing and dietary services; patient diagnosis, assessment and treatment; individual, family and group counseling; and educational and support services, including a designated unit of a licensed health care facility providing any and all other services specified in this paragraph to patients with the illnesses of alcoholism and drug dependency.

Treatment plan means a written plan initiated at the time of admission, approved by a Doctor of Medicine, Doctor of Osteopathy or a Registered Substance Abuse Counselor employed by a certified or licensed substance abuse program, including, but not limited to, the patient's medical, drug and alcoholism history; record of physical examination; diagnosis; assessment of physical capabilities; mental capacity; orders for medication, diet and special needs for the patient's health or safety and treatment, including medical, psychiatric, psychological, social services, individual, family and group counseling; and educational, support and referral services.

7. The definition entitled "Physician" in the DEFINITIONS section of Your Certificate to include a pastoral counselor licensed by the state of Maine, for Covered Services which are within the scope of his or her license, and when benefits would be payable if the services were provided by a doctor of medicine (M.D.).

Telemedicine Services

Coverage provided through telemedicine is payable on the same basis as health care services provided through in-person consultation between the Covered Person and a health care provider. Coverage for health care services provided through telemedicine must be determined in a manner consistent with coverage for health care services provided through in-person consultation.

“Telemedicine”, as it pertains to the delivery of health care services, means the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. “Telemedicine” does not include the use of audio-only telephone, facsimile machine or e-mail.

CERTIFICATE AMENDMENT

to the Certificate of Insurance

For: Covered Persons residing in Maryland

Your Certificate of Insurance is amended to conform to the requirements of the state of Maryland.

Any limitations and exclusions contained in Your Certificate of Insurance which are in conflict with these requirements are hereby amended to comply with the minimum state requirements.

Benefits payable under this Amendment are reduced to the extent that benefits are payable for the same expenses under the Medical Benefit or Outpatient Prescription Drug Benefit, if applicable.

The provisions on the following pages form part of this Certificate Amendment.

All other terms and conditions shown in Your Certificate of Insurance will continue to apply.

HEALTH NET LIFE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read "S. Sell", written in a cursive style.

Steven Sell

President

1. The **Treatment of Non-Severe Mental Disorders** and **Treatment for Chemical Dependency** sections of the SCHEDULE OF BENEFITS of Your Certificate are deleted and *replaced* with the following:

Mental Illness, Emotional Disorder, Drug Abuse Disorder and Alcohol Abuse Disorder

Coverage shall be provided on the same basis as any other illness subject to the following:

Number of days partial hospitalization per Calendar Year 60

Outpatient coverage is subject to a Coinsurance amount of:

- 20% for the first 5 visits per Calendar Year;
- 35% for the 6th through 30th visit per Calendar Year;
- 50% for the 31st and subsequent visit per Calendar Year.

The definition of “Mental Disorder” in the DEFINITIONS section of Your Certificate is amended to include coverage for psychological and neuropsychological testing for diagnostic purposes.

2. The **Age Limit for Children** subsection of the ELIGIBILITY, ENROLLMENT AND TERMINATION section is revised to add the following provision.

If a full-time student becomes enrolled less than full-time due to a documented disability that prevents the student from maintaining a full-time course load, and is maintaining a course load of at least 7 credit hours per semester, coverage will continue until he or she reaches the limiting age for students.

In order to continue the coverage, the student must provide verification of the disability from a disability services professional employed by the institution of higher education that the student attends or a health care provider with special expertise in and knowledge of the disability.

3. The following benefits are added to the **Additional Services and Supplies** section of the Medical Benefit section of Your Certificate. These benefits are in addition to any coverage otherwise payable under the Medical Benefit.

Off-Label Prescription Drug Use

1. If coverage is provided under the Medical Benefit or the Outpatient Prescription Drug Benefit, if applicable, coverage will be provided for prescription drugs for a treatment for which the prescription drug has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific treatment for which it has been prescribed in one of the following established reference compendia:
 - a. the American Medical Association Drug Evaluations;
 - b. the American Hospital Formulary Service Drug Information;
 - c. the United States Pharmacopeia Drug Information;or, it is recommended by a clinical study or review article in a major peer-reviewed professional journal.
2. The coverage required pursuant to this section:
 - a. Includes coverage for any Medically Necessary services to administer the drug to the Covered Person.
 - b. Does not include coverage for any:
 - drug which is deemed Experimental or if Investigational; or
 - use of a drug that is contraindicated by the Food and Drug Administration for the treatment for which it is prescribed.

Medical Foods and Low protein Modified Food Products

Coverage is provided for expenses incurred in the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods and low protein modified food products when diagnosed and determined to be Medically Necessary by the Covered Person's Physician, and administered under the direction of a Physician.

"Inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry for which the state of Maryland screens newborn babies. "Low protein modified food product" means a food product that is specially formulated to have less than one gram of protein per serving dietary treatment of an inherited metabolic disease, but does not include a natural food that is naturally low in protein; and "medical food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered enterally under direction of a Physician.

Benefits are provided to the same extent as for any other illness under the plan.

Child Wellness Services

Coverage is provided for child wellness services that are consistent with:

- public health policy;
- professional standards; and
- scientific evidence of effectiveness.

Child wellness services include:

- (i) all visits for and costs of childhood and adolescent immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control;
- (ii) visits for the collection of adequate samples, the first of which is to be collected before 2 weeks of age, for hereditary and metabolic newborn screening and follow-up between birth and 4 weeks of age;
- (iii) universal hearing screening of newborns provided by a Hospital before discharge;
- (iv) all visits for and costs of age-appropriate screening tests for tuberculosis, anemia, lead toxicity, hearing, and vision as determined by the American Academy of Pediatrics;
- (v) a physical examination, developmental assessment, and parental anticipatory guidance services at each of the visits required under items (i), (ii), and (iv) above; and
- (vi) any laboratory tests considered necessary by the Physician as indicated by the services provided under items (i), (ii), (iv), or (v) above.

Treatment of Cleft Lip and Cleft Palate

Coverage is provided for inpatient or outpatient expenses arising from orthodontics, oral surgery, and otologic audiological and speech language treatment involved in the management of cleft lip and/or cleft palate.

Diagnosis and Treatment of Osteoporosis

Coverage is provided for a Covered Person who is a qualified individual for scientifically proven bone mass measurement for the diagnosis and treatment of osteoporosis.

1. “Bone mass measurement” means a radiologic or radioisotopic procedure or other scientifically proven technologies performed on a qualified individual for the purpose of identifying bone mass or detecting bone loss.
2. “Qualified individual” means:
 - a) an estrogen deficient individual at clinical risk for osteoporosis;
 - b) an individual with a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;
 - c) an individual receiving long-term glucocorticoid (steroid) therapy;
 - d) an individual with primary hyperparathyroidism; or
 - e) an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

Prostate Cancer Screening Coverage

Coverage is provided for an annual medically recognized diagnostic examination for the detection of prostate cancer of a Covered Person. Coverage includes:

1. for men who are between 40 and 75 years of age;
2. when used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment;
3. when used for staging in determining the need for a bone scan in patients with prostate cancer; or
4. when used for male patients who are at high risk for prostate cancer.

General Anesthesia In Conjunction with Dental Care

Coverage is provided for general anesthesia and associated Hospital or Ambulatory Surgical Center charges in conjunction with dental care provided to a Covered Person insured if such Covered Person is:

1. Seven years of age or younger or is developmentally disabled;
2. An individual for which a successful result cannot be expected from dental care provided under local anesthesia because of a neurological or other medically compromising condition of the Covered Person; or
3. An individual for whom a superior result can be expected from dental care under general anesthesia;
4. An individual for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth or other increased, oral or dental morbidity; or
5. An individual who is an extremely uncooperative, fearful, or uncommunicative child who is 17 years of age or younger with dental needs of such magnitude that treatment should not be delayed or deferred.

Coverage for general anesthesia and associated hospital or ambulatory facility charges to dental care will only be payable if the treatment is provided by:

- a. a fully accredited specialist in pediatric dentistry;
- b. a fully accredited specialist in oral and maxillofacial surgery; and
- c. a dentist to whom Hospital privileges have been granted.

Coverage is not provided for dental care rendered for temporal mandibular joint disorders.

Chlamydia Screening Testing

Coverage is provided for an annual routine chlamydia screening test for:

- (1) women who are:
 - under the age of 20 years if they are sexually active; and
 - at least 20 years old if they have multiple risk factors; and
- (2) men who have multiple risk factors.

“Chlamydia screening test” means any laboratory test that:

- specifically detects for infection by one or more agents of chlamydia trachomatis; and
- is approved for this purpose by the federal Food and Drug Administration.

“Multiple risk factors” means having a prior history of a sexually transmitted disease, new or multiple sex partners, inconsistent use of barrier contraceptives, or cervical ectopy.

Colorectal Cancer Screening

Coverage is provided for colorectal cancer screening in accordance with the latest guidelines issued by the American Cancer Society on the same basis as coverage for any other illness.

Hearing Aids for Minor Dependent Children

Coverage is provided for hearing aids for a minor Dependent Child, if the hearing aids are prescribed, fitted and dispensed by an audiologist licensed by the state of Maryland. Coverage is limited to a maximum of \$1,400 per hearing aid for each hearing-impaired ear during every 36 months.

“Hearing aid” means a device that:

- is of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by children; and
- is nondisposable.

4. The **Care for Conditions of Pregnancy** section of the Medical Benefit is revised to *delete* the following paragraph:

If You are discharged earlier than 48 hours after a vaginal delivery or 96 hours after a cesarean section, Your Physician may arrange a home visit during the first 48 hours following discharge by a licensed health care provider whose scope of practice includes postpartum care and newborn care. This home visit does not require Certification.

and to add the following paragraph:

If You are discharged after a vaginal delivery or 96 hours after a cesarean section, Your Physician may arrange a home visit during the first 24 hours following discharge and one additional home visit if Medically Necessary, by a licensed health care provider whose scope of practice includes postpartum care and new home care. These home visits do not require Certification.

5. Benefits for “Services for Non-Severe Mental Disorders” and “Chemical Dependency Services” under the Medical Benefit section of Your Certificate are deleted and *replaced* by the following:

Services for Mental Illness, Emotional Disorder, Drug Abuse Disorder and Alcohol Abuse Disorder

Covered Services for the treatment are payable on the same basis as coverage for any other illness under the plan, subject to any benefit maximums specified in the SCHEDULE OF BENEFITS section of Your Certificate.

Coverage is only provided if, in the professional judgment of health care providers the treatment of the mental illness, emotional disorder, drug abuse or alcohol abuse is treatable and the treatment is Medically Necessary.

As used in this benefit:

“Alcohol abuse” has the meaning stated in § 8-101 of the Health-General Article.

“Drug abuse” has the meaning stated in § 8-101 of the Health-General Article.

“Partial hospitalization” means the provision of medically directed intensive or intermediate short-term treatment:

- a. to an insured;
 - b. in a licensed or certified facility or program;
 - c. for mental illness, emotional disorders, drug abuse, or alcohol abuse; and
 - d. for a period of less than 24 hours but more than 4 hours in a day.
6. The GENERAL LIMITATIONS AND EXCLUSIONS section of Your Certificate is *revised* to remove any limitation or exclusion for loss to which a contributing cause was Your commission of or the attempt to commit a felony.

CERTIFICATE AMENDMENT

to the Certificate of Insurance

For: Covered Persons residing in Massachusetts

Your Certificate of Insurance is amended to conform to the requirements of the state of Massachusetts.

Any limitations and exclusions contained in Your Certificate of Insurance which are in conflict with these requirements are hereby amended to comply with the minimum state requirements.

Benefits payable under this Amendment are reduced to the extent that benefits are payable for the same expenses under the Medical Benefit or Outpatient Prescription Drug Benefit, if applicable.

The provisions on the following pages form part of this Certificate Amendment.

All other terms and conditions shown in Your Certificate of Insurance will continue to apply.

HEALTH NET LIFE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read "S. Sell", is positioned above the printed name and title.

Steven Sell

President

1. The **Treatment of Non-Severe Mental Disorders** and **Treatment for Chemical Dependency** sections of the SCHEDULE OF BENEFITS of Your Certificate are deleted and *replaced* with the following:

Mental Disorders

Inpatient Treatment

Number of days Inpatient Hospital Services per Calendar Year..... 60
Where Medically appropriate, two days of outpatient treatment at a community mental health center or other mental health clinic or psychiatric day treatment center licensed by the Massachusetts department of public health or two days of outpatient day treatment at a psychiatric Hospital licensed by the Massachusetts department of mental health, may be substituted for one day of inpatient hospital care.

Outpatient Treatment

Maximum Benefit for Calendar Year..... \$500

Substance Abuse

Intensive Detoxification and Rehabilitation Services (inpatient)

Maximum benefit per Calendar Year..... 30 days of care

Outpatient Care in a Residential Treatment Program

Maximum benefit per Calendar Year..... \$500

2. The **Additional Services and Supplies** subsection of the Medical Benefit section of Your Certificate of Insurance is revised to delete “Diabetic Equipment” and to *substitute* the following:

Diabetes Management and Treatment

Coverage is provided for the following items when Medically Necessary for the diagnosis or treatment of insulin-dependent, insulin-using, gestational and non-insulin-dependent diabetes:

- blood glucose monitors;
- blood glucose monitoring strips for home use;
- voice-synthesizers for blood glucose monitors for use by the legally blind;
- visual magnifying aids for use by the legally blind;
- urine glucose strips;
- ketone strips;
- lancets;
- insulin;
- insulin syringes;
- prescribed oral diabetes medications that influence blood sugar levels;
- laboratory tests, including glycosylated hemoglobin, or HbA1c, tests;
- urinary protein/microalbumin and lipid profiles;
- insulin pumps and insulin pump supplies;
- insulin pens, so-called;

- therapeutic/molded shoes and shoe inserts for Covered Persons who have severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the treating Physician and prescribed by a podiatrist or other qualified Physician and furnished by a podiatrist, orthotist, prosthetist or pedorthist;
- supplies and equipment approved by the Federal Drug Administration for the purposes for which they have been prescribed and diabetes outpatient self-management training and education, including medical nutrition therapy, when provided by a certified diabetes health care provider who is a Participating Provider affiliated with a Participating Provider.

“Certified diabetes health care provider” means a licensed health care professional with expertise in diabetes, a registered dietician or a health care provider certified by the National Certification Board of Diabetes Educators as a certified diabetes educator.

3. The **Additional Services and Supplies** subsection of the Medical Benefit section of Your Certificate of Insurance is revised to delete “Coverage for Clinical Trials” and *substitute* the following:

Coverage for Clinical Trials

Coverage is provided for patient care service furnished pursuant to qualified clinical trials to the same extent as they would be covered and reimbursed if the patient did not receive care in a qualified clinical trial. “Patient care service” means a health care item or service that is furnished to an individual enrolled in a qualified clinical trial which is consistent with the usual and customary standard of care for someone with the patient’s diagnosis, is consistent with the study protocol for the clinical trial, and would be covered if the patient did not participate in the clinical trial.

A clinical trial is a “qualified clinical trial” if it meets the following conditions:

1. the clinical trial is to treat cancer;
2. the clinical trial has been peer reviewed and approved by one of the following:
 - i. United States National Institutes of Health;
 - ii. a cooperative group or center of the National Institutes of Health;
 - iii. a qualified nongovernmental research entity identified in guidelines issued by the National Institutes of Health for center support grants;
 - iv. the United States Food and Drug Administration pursuant to an investigational new drug exemption;
 - v. the United States Departments of Defense or Veterans Affairs; or
 - vi. with respect to Phase II, III and IV clinical trials only, a qualified institutional review board.
3. the facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that experience;
4. with respect to Phase I clinical trials, the facility shall be an academic medical center or an affiliated facility and the clinicians conducting the trial shall have staff privileges at said academic medical center;
5. the patient meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial;
6. the patient has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards;

7. the available clinical or pre-clinical data provide a reasonable expectation that the patient's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial;
8. the clinical trial does not unjustifiably duplicate existing studies; and
9. the clinical trial must have a therapeutic intent and must, to some extent, assume the effect of the intervention on the patient.

Coverage for qualified clinical trials is subject to all the other terms and conditions of the plan.

4. The **Care for Conditions of Pregnancy** section of the Medical Benefit is revised to delete the following paragraph:

If You are discharged earlier than 48 hours after a vaginal delivery or 96 hours after a cesarean section, Your Physician may arrange a home visit during the first 48 hours following discharge by a licensed health care provider whose scope of practice includes postpartum care and newborn care. This home visit does not require Certification.

and to add the following paragraph:

If You after consultation with her Physician are discharged earlier than 48 hours after a vaginal delivery or 96 hours after a caesarian section, coverage will be provided for home visits, parent education, assistance and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests; provided, however, that the first home visit will be conducted by a registered nurse, physician, or certified nurse midwife; and provided, further, that any subsequent home visit determined to be clinically necessary shall be provided by a licensed health care provider.

5. The following benefits are added to the **Additional Services and Supplies** section of Your Certificate. These benefits are in addition to any coverage otherwise payable under the Medical Benefit, or Outpatient Prescription Drug Benefit.

Scalp Hair Protheses

Coverage is provided under the plan for scalp hair protheses worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia. Such coverage, however, will be subject to a written recommendation by the treating Physician stating that the hair prosthesis is Medically Necessary. Such coverage shall be subject to the same limitations and guidelines as other protheses covered under the plan. Scalp hair prosthesis coverage is subject to a Calendar Year Maximum Amount of \$350.

Off-Label Prescription Drug Use

1. If coverage is provided under the Medical Benefit or the Outpatient Prescription Drug Benefit, if applicable, coverage will be provided for prescription drugs for treatment of a specific type of cancer, for which the prescription drug has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific treatment for which it has been prescribed in one of the following established reference compendia:
 - a. the American Hospital Formulary Service Drug Information; or
 - b. the United States Pharmacopeia Drug Information;or, it is recommended in medical literature.
2. The coverage required pursuant to this section:
 - a. Includes coverage for any Medically Necessary services to administer the drug to the Covered Person.
 - b. Does not include coverage for any:
 - drug which is deemed Experimental or if Investigational; or
 - use of a drug that is contraindicated by the Food and Drug Administration for the treatment for which it is prescribed.

Coverage for Nonprescription Enteral Formulas

Coverage is provided for nonprescription enteral formulas for home use for which a Physician has issued a written order and which are Medically Necessary for the treatment of malabsorption cause by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids. Coverage for inherited diseases of amino acids and organic acids includes food products modified to be low protein and is subject to Calendar Year Maximum Amount of \$5,000.

Infertility Coverage

Coverage is provided for Medically Necessary diagnosis and treatment of infertility of Covered Persons who are presumably healthy individuals who have been unable to conceive or produce conception during a period of at least one year.

Coverage will be provided on the same basis as any other illness. Benefits will be reduced if certification is not obtained for the diagnosis or treatment.

Cytologic testing: mammograms

In addition to the coverage provided under "Preventive Care for Adults" in Your Certificate of Insurance, coverage is provided for an annual cytologic screening test for women age 18 or older and for a baseline mammogram for women between the ages of 35 and 40 and a mammogram on an annual basis for women 40 years of age or over.

Cardiac Rehabilitation

Coverage is provided for multidisciplinary, Medically Necessary treatment of Covered Persons with documented cardiovascular disease, provided in either a Hospital or other setting and which shall meet standards promulgated by the commissioner of public health of Massachusetts. Such standards include, but not be limited to, outpatient treatment which is to be initiated within twenty-six weeks after the diagnosis of such disease.

Newborn Child Coverage

Coverage is in addition to Preventive Care benefits and Phenylketonuria coverage provided under the plan.

Coverage consists of coverage of Injury or illness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, or premature birth. Coverage also includes those special medical formulas which are approved by the commissioner of the department of public health, prescribed by a Physician, and are Medically Necessary for treatment of tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia, or methylmalonic acidemia in infants and children or Medically Necessary to protect the unborn fetuses of pregnant women with phenylketonuria. Coverage also includes screening for lead poisoning as required by Massachusetts regulations.

Early Childhood Intervention

Coverage is provided for Medically Necessary early intervention services delivered by certified early intervention specialists, as defined in the early intervention operational standards by the Massachusetts Department of Public Health and in accordance with applicable certification requirements. Such Medically Necessary services shall be provided by early intervention specialists who are working in early intervention programs certified by the Massachusetts Department of Public Health, as provided in sections 1 and 2 of chapter 111G, for children from birth until their third birthday. Reimbursement of costs for such services will be provided, with a maximum benefit of \$5,200 per Calendar Year per child and an aggregate benefit of \$15,600 over the total enrollment period.

Certification is not required.

Preventive and Primary Care Services for Children

Coverage is provided for preventive and primary care services for children. Preventive care services means services rendered to a Dependent child of a Covered Person from the date of birth through the attainment of six years of age and includes physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and development screening, and assessment at the following intervals: six times during the child's first year after birth, three times during the next year, annually until age six. Such services also include hereditary and metabolic screening at birth, appropriate immunizations, and tuberculin tests, hematocrit, hemoglobin or other appropriate blood tests, and urinalysis as recommended by the Physician.

Leukocyte Testing Coverage

Coverage is provided for the cost of human leukocyte antigen testing or histocompatibility locus antigen testing that is necessary to establish stem cell transplant donor suitability. Coverage consists of the costs of testing for A, B or DR antigens, or any combination thereof, consistent with rules, regulations and criteria established by the Massachusetts department of public health pursuant to section 218 of chapter 111.

Speech, Hearing and Language Disorders Coverage

Coverage is provided for the expenses incurred in the Medically Necessary diagnosis and treatment of speech, hearing and language disorders by individuals licensed as speech-language pathologists or audiologists under the provisions of Massachusetts chapter if such services are rendered within the lawful scope of practice for such speech-language pathologists or audiologists regardless of whether the services are provided in a Hospital, clinic or private office.

Hormone Replacement Therapy

Coverage is provided for hormone replacement therapy services for pre- and post-menopausal women and outpatient contraceptive services under the same terms and conditions as for other outpatient services. Outpatient contraceptive services are defined to include consultations, examination, procedures and medical services provided on an outpatient basis and related to the use of all contraceptive methods to prevent pregnancy that have been approved by the United States Food and Drug Administration.

Prosthetic Devices to Replace Arm or Leg

Coverage is provided for prosthetic devices or repairs, on the same basis as any other illness or injury under the Certificate, provided that the prosthetic device is an artificial limb device to replace in whole or in part, an arm or leg.

This coverage shall not be subject to any Calendar Year Maximum for Durable Medical Equipment that would otherwise apply under the Certificate.

6. Benefits for “Services for Severe Mental Illness” and “Severe Emotional Disturbances of a Child” under the Medical Benefit section of Your Certificate are deleted and *replaced* by the following:

Mental Health & Substance Use Disorders

Coverage is provided for a range of inpatient, intermediate and outpatient mental health services for the treatment of mental health disorders so that Medically Necessary and active, noncustodial treatment may take place in the least restrictive clinically appropriate setting.

“Mental health disorders” means mental health disorders as described in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association (“DSM”).

Mental health services required covered are those that diagnose and/or treat an Illness, disease or health condition in order to reduce or alleviate symptoms and/or improve an individual's emotional or behavioral functioning. Educational services to improve an individual's academic performance or developmental functioning are not required services under the benefit mandate for mental health services. The treatment sessions could be with the child and/or with parent(s) and/or other caregivers.

Medical Necessity

Coverage is provided only if the health care services (1) are a covered benefit under the Certificate of Insurance; and (2) the services are Medically Necessary.

We will consider the individual health care needs of the Covered Person in applying such guidelines. In accordance with M.G.L. c. 176O, an individual may appeal a decision by Us to reduce or modify a request for authorization of covered intermediate care based on Our Medical Necessity criteria.

Levels of Service

Inpatient Services - 24-hour services, delivered in a licensed general Hospital, a psychiatric Hospital or a substance abuse facility, that provide evaluation and treatment for an acute psychiatric condition or substance use diagnosis, or both.

Intermediate Services - A range of non-inpatient services that provide more intensive and extensive treatment interventions when outpatient services alone are not sufficient to meet the patient's needs. Intermediate Services, include, but are not limited to, the following:

Acute and other residential treatment – Mental health services provided in a 24-hour setting, with clinical staff and appropriately trained professional and paraprofessional staff to insure safety for the individual, while providing active treatment and reassessment.

Clinically managed detoxification services – 24 hour, seven days a week, clinically managed detoxification services in a licensed non-hospital setting that include 24 hour per day supervision, observation and support, and nursing care, seven days a week.

Partial hospitalization - Short-term day/evening mental health programming available five to seven days per week. These services consist of therapeutically intensive acute treatment within a therapeutic milieu and include daily psychiatric management.

Intensive Outpatient Programs (IOP) – Multimodal, inter-disciplinary, structured behavioral health treatment provided over the course of two to three hours per day for multiple days per week in an outpatient setting. Includes, but is not limited to, diagnosis, evaluation and treatment of mental health and substance use disorders.

Day treatment - Services based on a planned combination of diagnostic, treatment and rehabilitative approaches to a person with mental illness or substance use disorder who needs more active or intensive treatment. Day treatment programs encompass generally some portion of a day or week rather than a weekly visit to a mental health clinic, individual provider's office or hospital outpatient department. The individual does not need 24-hour hospitalization or partial hospitalization.

Crisis stabilization – Short-term psychiatric treatment in structured, community-based therapeutic environments. Community Crisis Stabilization provides continuous 24-hour observation and supervision for individuals who do not require Inpatient Services.

In-home therapy services – An intensive combination of diagnostic and treatment interventions delivered in the home and community to a youth and family designed to sustain the youth in his or her home and/or to prevent the youth's admission to an inpatient hospital, psychiatric residential treatment facility, or other psychiatric treatment setting.

The following are not considered intermediate services and are not Covered Charges;

- Programs in which the patient has a pre-defined duration of care without Our ability to conduct concurrent determinations of continued Medical Necessity for an individual.
- Programs that only provide meetings or activities that are not based on individualized treatment planning.
- Programs that focus solely on improvement in interpersonal or other skills rather than treatment directed toward symptom reduction and functional recovery related to amelioration of specific psychiatric symptoms or syndromes.
- Tuition-based programs that offer educational, vocational, recreational or personal development activities, such as a therapeutic school, camp or wilderness program. We will provide coverage for Medically Necessary outpatient or intermediate services provided while the individual is in the program, subject to the terms of the Certificate of Insurance including any network requirements or co-payments/coinsurance provisions.
- Programs that provide primarily custodial care services.

Outpatient Services - Services provided in person in an ambulatory care setting. Outpatient services may be provided in a licensed Hospital, a mental health or substance abuse clinic licensed by the department of public health, a public community mental health center, a professional office or

home-based services. Such services delivered in such offices or settings are to be rendered by a licensed mental health professional (a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, or a licensed nurse mental health clinical specialist) acting within the scope of his/her license.

Services Provided in an Intermediate Care Setting

In a particular case, We may determine that a specific level of intermediate care is not Medically Necessary but instead will provide coverage for outpatient services or a different level of intermediate care. If, despite such determination, the patient elects to receive the originally requested intermediate care, We will provide coverage for any Medically Necessary outpatient services or other authorized level of intermediate care provided while the individual is in the intermediate care setting, subject to the terms of the Certificate of Insurance including any network restrictions or co-payment/coinsurance provisions. Medically Necessary outpatient or other intermediate services will not be denied simply because the patient is receiving non-authorized intermediate care. These outpatient services or other intermediate care services will be reviewed under Our concurrent review system.

Level of Benefits for Intermediate Care Services

The duration of intermediate care services authorized for any particular individual will vary according to that person's individual needs. The authorization of benefits for intermediate care will not affect the minimum benefits for non-biologically based conditions.

7. Benefits for “Services for Severe Mental Illness” and “Severe Emotional Disturbances of a Child” under the Medical Benefit section of Your Certificate are deleted and *replaced* by the following:

SEVERE MENTAL ILLNESS/SERIOUS EMOTIONAL DISTURBANCES

- a. Coverage is provided under the plan for the diagnosis and Medically Necessary treatment of severe mental illnesses of a person of any age, and non-biologically-based mental, behavioral or emotional disorders of a child or adolescent, under the same terms and conditions applied to other medical conditions under the plan, as specified in subdivision (c)., below;
- b. These benefits include the following:
 1. Outpatient services.
 2. Inpatient Hospital services.
 3. Partial Hospital services.
 4. Outpatient Prescription Drugs coverage for prescription drugs if coverage is provided for other illness or Injury under the plan.
- c. Coverage for severe mental illness and serious emotional disturbances of a child shall be covered under the same conditions as any other illness including, but not limited to the following:
 1. Maximum lifetime benefits.
 2. Copayments and Coinsurance.
 3. Individual and family Deductibles.

- d. For the purposes of this benefit, “severe mental illnesses” include the following, as described in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (“DSM”).
1. Schizophrenia.
 2. Schizoaffective disorder.
 3. Bipolar disorder (manic-depressive illness).
 4. Major depressive disorders.
 5. Panic disorder.
 6. Obsessive-compulsive disorder.
 7. Pervasive developmental disorder or autism.
 8. Paranoia and other psychotic disorders.
 9. Delirium and dementia.
 10. Affective disorders.
 11. any other biologically-based mental disorders appearing in the DSM that are scientifically recognized and approved by the commissioner or the department of mental health in consultation with the commissioner of the division of insurance.

A child or adolescent suffering from non-biologically-based mental, behavioral or emotional disorders (as described in the most recent edition of the DSM) means a child or adolescent suffering from conditions which substantially interfere with or substantially limit the functioning and social interactions of such a child or adolescent; provided, that said interference or limitation is documented by and the referral for said diagnosis and treatment is made by the child’s or adolescent’s Physician, primary pediatrician or a licensed mental health professional of such a child or adolescent or is evidenced by conduct, including, but not limited to: (1) an inability to attend school as a result of such a disorder, (2) the need to hospitalize the child or adolescent as a result of such a disorder, or (3) a pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others. Coverage will also be provided to any adolescent who is engaged in an ongoing course of treatment beyond the adolescent’s nineteenth birthday until said course of treatment, as specified in said adolescent’s treatment plan, is completed and while the plan remains in effect.

Coverage is also provided for Medically Necessary diagnosis and treatment of all other mental disorders not otherwise provided for the above and which are described in the most recent edition of DSM during each 12 month period for a maximum 60 days of inpatient treatment and for a maximum of 24 outpatient visits.

Coverage is also provided, as any other illness, for the diagnosis and treatment of rape-related mental or emotional disorders to victims of a rape or victims of an assault with intent to commit rape, as defined by sections 22 and 24 of chapter 265 Massachusetts statutes, whenever the costs of such diagnosis and treatment exceed the maximum compensation awarded to such victims pursuant to subparagraph (C) of paragraph (2) of subsection (b) of section 3 of chapter 258C, Massachusetts statutes.

CERTIFICATE AMENDMENT

to the Certificate of Insurance

For: Covered Persons residing in Mississippi

Your Certificate of Insurance is amended to conform to the requirements of the state of Mississippi.

Any limitations and exclusions contained in Your Certificate of Insurance which are in conflict with these requirements are hereby amended to comply with the minimum state requirements.

Benefits payable under this Amendment are reduced to the extent that benefits are payable for the same expenses under the Medical Benefit or Outpatient Prescription Drug Benefit, if applicable.

The provisions on the following pages form part of this Certificate Amendment.

All other terms and conditions shown in Your Certificate of Insurance will continue to apply.

HEALTH NET LIFE INSURANCE COMPANY



Steven Sell

President

The following benefits are added to the **Additional Services and Supplies** section of the Medical Benefit section of Your Certificate. These benefits are in addition to any coverage otherwise payable under the Medical Benefit.

Off-Label Prescription Drug Use

1. If coverage is provided under the Medical Benefit or the Outpatient Prescription Drug Benefit, if applicable, coverage will be provided for prescription drugs for treatment of a specific type of cancer, for which the prescription drug has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific treatment for which it has been prescribed in one of the following established reference compendia:
 - a. the American Hospital Formulary Service Drug Information; or
 - b. the United States Pharmacopeia Drug Information;or, it is recommended in medical literature.

“Medical literature” means two (2) articles from major peer-reviewed professional medical journals that have recognized, based on scientific or medical criteria, the drug’s safety and effectiveness for treatment of the indication for which it has been prescribed unless two (2) articles from major peer-reviewed professional medical journals have concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed. Peer-reviewed medical literature shall not include publications or supplements that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

2. The coverage required pursuant to this section:
 - a. Includes coverage for any Medically Necessary services to administer the drug to the Covered Person.
 - b. Does not include coverage for any:
 - drug which is deemed Experimental or if Investigational; or
 - use of a drug that is contraindicated by the Food and Drug Administration for the treatment for which it is prescribed.

Temporomandibular Joint Disorder Coverage

Coverage is provided for Medically Necessary surgical and non-surgical treatment of temporomandibular joint disorder or craniomandibular joint disorder by a Physician, including a dentist, professionally qualified by training and experience.

Coverage is limited to a lifetime maximum of \$5,000.

CERTIFICATE AMENDMENT

to the Certificate of Insurance

For: Covered Persons residing in Montana

Your Certificate of Insurance is amended to conform to the requirements of the state of Montana.

Any limitations and exclusions contained in Your Certificate of Insurance which are in conflict with these requirements are hereby amended to comply with the minimum state requirements.

Benefits payable under this Amendment are reduced to the extent that benefits are payable for the same expenses under the Medical Benefit or Outpatient Prescription Drug Benefit, if applicable.

The provisions on the following pages form part of this Certificate Amendment.

All other terms and conditions shown in Your Certificate of Insurance will continue to apply.

HEALTH NET LIFE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read "S. Sell", is positioned above the printed name and title.

Steven Sell

President

The definition entitled "Medical Disorder" in the DEFINITIONS section of Your Certificate is *replaced* with the following definition:

Mental Disorder means a clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is associated with:

- (i) present distress or a painful symptom;
- (ii) a disability or impairment in one or more areas of functioning; or
- (iii) a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

Mental Disorder must be considered as a manifestation of a behavioral, psychological, or biological dysfunction in a person.

Mental Disorder does not include:

- (i) a developmental disorder;
- (ii) a speech disorder;
- (iii) a psychoactive substance use disorder;
- (iv) an eating disorder, except for bulimia and anorexia nervosa;
- (v) an impulse control disorder, except for intermittent explosive disorder and trichotillomania; or
- (vi) a severe mental illness, as defined elsewhere in Your Certificate.

2. The **Treatment of Non-Severe Mental Disorders** and **Treatment for Chemical Dependency** sections of the SCHEDULE OF BENEFITS of Your Certificate are deleted and *replaced* with the following:

Mental Disorders

Inpatient Treatment

Number of days Inpatient Hospital Services per Calendar Year..... 21

Where Medically appropriate, inpatient treatment for Mental Disorders may be traded on a 2-for-1 basis for a benefit for partial hospitalization through a program that complies with the standards for a partial hospitalization program that are published by the American association for partial hospitalization if the program is operated by a Hospital;

Outpatient Treatment

Maximum Benefit for Calendar Year..... \$2,000

Substance Abuse

Medical Detoxification and Rehabilitation Services

Maximum benefit per Calendar Year..... Treated as any other illness under the plan

Inpatient and Outpatient care other than detoxification

Maximum benefit per 12 month period..... \$6,000*

* After a Covered Person has incurred \$12,000 of inpatient and/or outpatient treatment during such Covered Person's lifetime, the maximum benefit during any subsequent 12 month period will be limited to \$2,000.

3. The **Age Limit for Children** subsection of the ELIGIBILITY, ENROLLMENT AND TERMINATION section of Your Certificate is *replaced* with the following:

Age Limit for Children

An unmarried child is eligible until age 25 (the limiting age): (i) who is not an employee eligible for coverage under a group health plan offered by the child's employer for which the child's premium contribution amount is no greater than the premium amount for coverage as a Dependent under a parent's individual or group health plan; (ii) who is not a named subscriber, insured, enrollee, or covered individual under any other individual health insurance coverage, group health plan, government plan, church plan, or group health insurance coverage; (iii) who is not entitled to Social Security benefits under § 42 U.S.C. 1395, et seq.; and (iv) for whom the insured parent has requested coverage.

4. The **Additional Services and Supplies** subsection of the Medical Benefit section of Your Certificate of Insurance is revised to *add* the following to **Mammography** under **Preventive Care for Adults**.

No Copayment, Coinsurance or Deductible Amounts will apply to the first \$70 of Covered Expenses incurred for mammography.

5. The **Additional Services and Supplies** subsection of the Medical Benefit section of Your Certificate of Insurance is revised to delete **Phenylketenuria (PKU)** and *substitute* the following:

PKU Coverage

Coverage is provided for the treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism and for which medically standard methods of diagnosis, treatment, and monitoring exist.

Coverage includes expenses of diagnosing, monitoring, and controlling the disorders by nutritional and medical assessment, including but not limited to clinical services, biochemical analysis, medical supplies, prescription drugs, corrective lenses for conditions related to the inborn error of metabolism, nutritional management, and medical foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

“Medical foods” means nutritional substances in any form that are:

- (i) formulated to be consumed or administered externally under supervision of a Physician;
- (ii) specifically processed or formulated to be distinct in one or more nutrients present in natural food;
- (iii) intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and
- (iv) essential to optimize growth, health, and metabolic homeostasis;

“Treatment” means licensed professional medical services under the supervision of a Physician.

6. The following benefits are *added* to the **Additional Services and Supplies** subsection of Your Certificate. These benefits are in addition to any coverage otherwise payable under the Medical Benefit, or Outpatient Prescription Drug Benefit.

Mastectomy and Breast Cancer Treatment

Benefits are payable for Medically Necessary inpatient care following a mastectomy, lumpectomy or a lymph node dissection for the treatment of breast cancer, for the period of time determined by the attending Physician, in consultation with the patient.

Well-child Care Coverage

Coverage is provided for well-child care for children from the moment of birth through 2 years of age. No Deductible will apply to this coverage.

Coverage for well-child care under subsection (1) includes:

- a. a history, physical examination, developmental assessment, anticipatory guidance, and laboratory tests, according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment services program provided for in 53-6-101 Montana Code Annotated ; and
- b. routine immunizations according to the schedule for immunizations recommended by the immunization practices advisory committee of the U.S. department of health and human services.

Benefits are limited to one visit payable to one provider for all of the services provided at each visit.

For purposes of this section:

“Well-child care” means the services described above and delivered by a Physician or a health care professional supervised by a Physician; and

“Developmental assessment” and “anticipatory guidance” mean the services described in the guidelines for health supervision II, published by the American academy of pediatrics.

Autism Spectrum Disorder

Coverage is provided for diagnosis and treatment of autism spectrum disorders for a covered child 18 years of age or younger.

Coverage is provided to a child who is diagnosed with one of the following disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders:

- a. autistic disorder;
- b. Asperger's disorder; or
- c. pervasive developmental disorder not otherwise specified.

Coverage includes:

- i. habilitative or rehabilitative care that is prescribed, provided, or ordered by a licensed Physician or licensed psychologist, including but not limited to professional, counseling, and guidance services and treatment programs that are medically necessary to develop and restore, to the maximum extent practicable, the functioning of the covered child;
- ii. medications prescribed by a Physician licensed under the Montana Professions and Occupation Code, Chapter 3;

- iii. psychiatric or psychological care; and
- iv. therapeutic care that is provided by a speech-language pathologist, audiologist, occupational therapist, or physical therapist licensed in this state.

Habilitative and rehabilitative care includes Medically Necessary interactive therapies derived from evidence-based research, including applied behavior analysis, which is also known as Lovaas therapy, discrete trial training, pivotal response training, intensive intervention programs, and early intensive behavioral intervention.

Applied behavior analysis must be provided by an individual who is licensed by the behavior analyst certification board or is certified by the department of public health and human services as a family support specialist with an autism endorsement.

Coverage for treatment of autism spectrum disorders is limited to a maximum benefit of:

- i. \$50,000 a year for a child 8 years of age or younger; and
- ii. \$20,000 a year for a child 9 years of age through 18 years of age.

Benefits provided do not limit physical health benefits that are otherwise available to the covered child.

Coverage is subject to Deductibles, Coinsurance, and Copayment provisions.

When treatment is expected to require continued services, We may request that the treating Physician provide a treatment plan consisting of diagnosis, proposed treatment by type and frequency, the anticipated duration of treatment, the anticipated outcomes stated as goals, and the reasons the treatment is Medically Necessary. The treatment plan must be based on evidence-based screening criteria. The treatment plan must be updated every 6 months.

As used above, "Medically Necessary" means any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a physician or psychologist licensed in Montana and that will or is reasonably expected to:

- a. prevent the onset of an Illness, condition, injury, or disability;
- b. reduce or improve the physical, mental, or developmental effects of an Illness, condition, injury, or disability; or
- c. assist in achieving maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and the functional capacities that are appropriate for a child of the same age.

CERTIFICATE AMENDMENT

to the Certificate of Insurance

For: Covered Persons residing in New Hampshire

Your Certificate of Insurance is amended to conform to the requirements of the state of New Hampshire.

Any limitations and exclusions contained in Your Certificate of Insurance which are in conflict with these requirements are hereby amended to comply with the minimum state requirements.

Benefits payable under this Amendment are reduced to the extent that benefits are payable for the same expenses under the Medical Benefit or Outpatient Prescription Drug Benefit, if applicable.

1. The **Treatment of Non-Severe Mental Disorders** and **Treatment for Chemical Dependency** sections of the SCHEDULE OF BENEFITS of Your Certificate are deleted and *replaced* with the following:

Mental Disorders or Chemical Dependency

Coverage shall be provided on the same basis as any other illness.

2. The Medical Benefit is revised as follows:

Care for Conditions of Pregnancy is hereby deleted and is *replaced* with the following:

PREGNANCY, DELIVERY AND POSTPARTUM COVERAGE

Coverage will be provided under the plan for the following during pregnancy, delivery and the postpartum period:

- a. The length of Hospital stay and the number of postpartum visits will be determined by the attending health care Provider based on clinical information that demonstrates that the mother and infant are clinically stable based on nationally accepted guidelines pursuant to paragraph IV below and that appropriate care for the mother and newborn can be provided for upon discharge. The length of stay shall not be determined by HNL or the Hospital based on economic criteria.
- b. Upon notification of the pregnancy by the Covered Person to Us, We will inform the pregnant woman in writing regarding the Covered Person's prenatal, maternity, and postpartum benefits, including but not limited to prenatal visits, diagnostic tests, prenatal education, Hospital length of stay, postpartum care, homemaker services, and contraceptive counseling and referrals.
- c. HNL will pay for Medically Necessary prenatal homemaker services when a woman is confined to bedrest or her activities of daily living are otherwise restricted on the recommendation of her attending health care Provider who shall consult with the applicable case manager, designated by Us.

- d. Any length of Hospital stay shorter than the current minimum nationally accepted guidelines for perinatal care, such as Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, will be at the recommendation of the attending health care Provider in consultation with the mother. In such cases, HNL will pay for at least 2 postpartum visits. During one such visit, the collection of an adequate sample from the newborn for screening for genetic and metabolic diseases shall take place in accordance with New Hampshire RSA 132 and applicable rules.
 - e. Postpartum visits shall include a physical assessment of mother and infant. The assessment shall include but not be limited to: infant nutrition and feeding, infant behavior, family interactions, safety and injury prevention, infant and maternal health promotion, and community resources. Providers of postpartum visits shall be licensed health care Providers experienced in perinatal care.
 - f. HNL will pay for appropriate Medically Necessary postpartum homemaker services as determined by the attending health care Providers who will consult with the applicable case manager designated by HNL.
 - g. No attending health care Provider will be penalized by HNL for following the provisions shown above. We will not deny payment for services that are within standards of good and generally accepted medical practice as reflected by scientific and peer medical literature and recognized within the organized medical community in the state of New Hampshire.
3. The **Age Limit for Children** subsection of the ELIGIBILITY, ENROLLMENT AND TERMINATION section of Your Certificate is *replaced* with the following:

Age Limit for Children

Each unmarried child is eligible until age 26 (the limiting age) who: (1) Is less than 26 years of age; (2) Is unmarried; (3) Is a resident of New Hampshire or is enrolled as a student at a public or private institution of higher education; and (4) Is not provided coverage as a named subscriber, insured, enrollee, or Covered Person under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or entitled to benefits under Title XVIII of the Social Security Act, Public Law 89-97, 42 U.S.C. 1395 et seq.

4. The following benefits are added to the **Additional Services and Supplies** section of Your Certificate. These benefits are in addition to any coverage otherwise payable under the Medical Benefit.

Scalp Hair Prostheses

Coverage is provided under the plan for scalp hair prostheses worn for hair loss suffered as a result of alopecia areata, alopecia medicamentosa resulting from the treatment from any form of cancer or leukemia, alopecia totalis, or permanent loss of scalp hair due to Injury. Such coverage, however, will be subject to a written recommendation by the treating Physician stating that the hair prosthesis is Medically Necessary. Such coverage shall be subject to the same limitations and guidelines as other prostheses covered under the plan.

As used above:

- a. **Prostheses** means artificial appliances used to replace lost natural structures. Prostheses include, but are not limited to, artificial arms, legs, breasts or glass eyes.
- b. **Scalp hair** prostheses means artificial substitutes for scalp hair that are made specifically for a specific individual.

Dental Procedures

Coverage is provided under the plan for the Medically Necessary Hospital or surgical day care facility charges and administration of general anesthesia administered by a licensed anesthesiologist or anesthesiologist for dental procedures performed on a Covered Person who:

- a. Is a child under the age of 6 who is determined by a licensed dentist in conjunction with a licensed Physician to have a dental condition of significant dental complexity which requires certain dental procedures to be performed in a surgical day care facility or Hospital setting; or
- b. Is a person who has exceptional medical circumstances or a developmental disability as determined by a licensed physician which place the person at serious risk.

Payment will be reduced if Certification is not available.

Leukocyte Testing Coverage

Coverage is provided for the cost of human leukocyte antigen testing or histocompatibility locus antigen testing that is necessary to establish stem cell transplant donor suitability. Coverage consists of the costs of testing for A, B or DR antigens, or any combination thereof. The testing must be performed in a facility that is accredited by the American Association of Blood Banks or its successors, or the College of American Pathologists, or its successors, or any other national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists, and is licensed under the Clinical Laboratory Improvement Act of 1967, 42 U.S.C. section 263a, as amended. At the time of the new testing, the person tested must complete and sign an informed consent form that also authorizes the results of the test to be used for participation in the National Marrow Donor Program.

Coverage for Obesity and Morbid Obesity

Coverage is provided for the diseases and ailments caused by obesity and morbid obesity and treatment for such, including bariatric surgery, when the prescribing Physician has issued a written order stating that treatment is Medically Necessary and in accordance with the patient qualifications and treatment standards set forth by the American Society for Metabolic and Bariatric Surgery or the American College of Surgeons. Such treatment standards include, but are not limited to, pre-operative psychological screening and counseling, behavior modification, weight loss, exercise regimens, nutritional counseling, and post-operative follow-up, overview, and counseling of dietary, exercise, and lifestyle changes. The Covered Person must be at least 18 years of age.

Coverage for Certified Midwives

Each insurer that issues or renews any policy of group or blanket accident or health insurance providing maternity benefits shall also provide to each group, or to the portion of each group comprised of certificate holders of such insurance who are residents of this state, coverage for services rendered by a midwife certified under New Hampshire statute RSA 326-D. Such coverage is subject to Our standards and mechanisms for credentialing and contracting pursuant to New Hampshire statutes RSA 420-J:4 and RSA 420-J:8 respectively, where applicable, and contingent upon services being provided in a licensed health care facility and within the scope of practice of a certified midwife.

5. The Conversion Coverage subsection of the ELIGIBILITY, ENROLLMENT, AND TERMINATION section is revised as follows:

You may choose a conversion plan that provides benefits equal to those provided to Covered Persons under the plan.

HNL will provide You written notice of Your conversion rights within 15 days of the date that Your Coverage under the plan terminates. If HNL fails to provide written notice within this 15 day period, the period of time which You may elect a conversion plan will be extended for a period of 15 days from the date that HNL provides the written notice.

The written notice that HNL mails You will include information concerning Your option of choosing a 39 week extension pursuant to New Hampshire RSA 415:18, vii(g)(4), instead of a conversion plan.

All of the terms and conditions of the plan will apply to these services.

All other terms and conditions shown in Your Certificate of Insurance will continue to apply.

HEALTH NET LIFE INSURANCE COMPANY



Steven Sell
President

CERTIFICATE AMENDMENT

to the Certificate of Insurance

For: Covered Persons residing in New York

Your Certificate of Insurance is amended to conform to the requirements of the state of New York.

Any limitations and exclusions contained in Your Certificate of Insurance which are in conflict with these requirements are hereby amended to comply with the minimum state requirements.

Benefits payable under this Amendment are reduced to the extent that benefits are payable for the same expenses under the Medical Benefit or Outpatient Prescription Drug Benefit, if applicable.

The provisions on the following pages form part of this Certificate Amendment.

All other terms and conditions shown in Your Certificate of Insurance will continue to apply.

HEALTH NET LIFE INSURANCE COMPANY



Steven Sell

President

1. The **Additional Services and Supplies** subsection of the Medical Benefit section of Your Certificate of Insurance is revised to add the following to “Diabetic Equipment”:

Coverage is also provided for insulin, insulin cartridges for the legally blind, infusion devices and oral agents for controlling blood sugar.

2. The following benefits are added to the **Additional Services and Supplies** subsection of Your Certificate. These benefits are in addition to any coverage otherwise payable under the Medical Benefit or Outpatient Prescription Drug Benefit, if applicable.

Coverage for Enteral Formulas

Coverage for the cost of enteral formulas for home use for which a Physician or other licensed health care provider legally authorized to prescribe under title eight of the education law of New York has issued a written order. Such written order shall state that the enteral formula is clearly Medically Necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic physical disability, mental retardation or death. Specific diseases for which enteral formulas have been proven effective include, but are not limited to, inherited diseases of amino-acid or organic acid metabolism; Crohn’s Disease; gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which if left untreated will cause malnourishment, chronic physical disability, mental retardation or death. Enteral formulas which are Medically Necessary and taken under written order from a Physician for the treatment of specific diseases must be distinguished from nutritional supplements taken electively. Coverage for certain inherited diseases of amino acid and organic acid metabolism will include modified solid food products that are low protein or which contain modified protein which are Medically Necessary. Coverage for such modified solid food products for any Calendar Year or for any continuous period of twelve months for any Covered Person is limited to a maximum of \$2,000.

Chiropractic Coverage

Coverage is provided for care or treatment rendered by a doctor of chiropractic in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

Preventive and Primary Care Services for Dependent Children Under Age 20

Coverage is provided for an initial hospital check-up and well-child visits scheduled in accordance with the prevailing clinical standards of a national association of pediatric physicians designated by the New York commissioner of health (except for any standard that would limit the specialty or forum of licensure of the practitioner providing the service other than the limits under New York state law). Coverage for such services rendered will be provided only to the extent that such services are provided by or under the supervision of a Physician, or other professional licensed under article one hundred thirty-nine of the education law of New York whose scope of practice pursuant to such law includes the authority to provide the specified services. Coverage will be provided for such services rendered in a hospital, as defined in section twenty-eight hundred one of the New York public health law, or in an office of a Physician or other professional licensed under article one hundred thirty-nine of the New York education law whose scope of practice pursuant to such law includes the authority to provide the specified services.

At each visit, services in accordance with the prevailing clinical standards of such designated association, including a medical history, a complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests which tests are ordered at the time of the visit and performed in the practitioner's office, as authorized by law, or in a clinical laboratory; and necessary immunizations as determined by the superintendent in consultation with the New York commissioner of health consisting of at least adequate dosages of vaccine against diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, haemophilus influenzae type b and hepatitis b which meet the standards approved by the United States public health service for such biological products.

Coverage is not subject to annual Deductibles and/or Coinsurance.

Off-Label Prescription Drug Use

1. If coverage is provided for prescription drugs under the Medical Benefit or the Outpatient Prescription Drug Benefit, if applicable, coverage will be provided for prescription drugs for the treatment of a certain type of cancer for which the prescription drug has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific treatment for which it has been prescribed in one of the following established reference compendia:
 - a. the American Medical Association Drug Evaluations;
 - b. the American Hospital Formulary Service Drug Information;
 - c. the United States Pharmacopeia Drug Information;or, it is recommended by a clinical study or review article in a major peer-reviewed professional journal.
2. The coverage required pursuant to this section:
 - a. Includes coverage for any Medically Necessary services to administer the drug to the Covered Person.
 - b. Does not include coverage for any:
 1. drug which is deemed Experimental or if Investigational; or
 2. use of a drug that is contraindicated by the Food and Drug Administration for the treatment for which it is prescribed.

Diagnostic Screening for Prostate Cancer

Coverage is provided for diagnostic screening for prostatic cancer as follows:

- (i) standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and
- (ii) an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate-specific antigen test for men age fifty and over who are asymptomatic and for men age forty and over with a family history of prostate cancer or other prostate cancer risk factors.

CERTIFICATE AMENDMENT

to the Certificate of Insurance

For: Covered Persons residing in North Dakota

Your Certificate of Insurance is amended to conform to the requirements of the state of North Dakota.

Any limitations and exclusions contained in Your Certificate of Insurance which are in conflict with these requirements are hereby amended to comply with the minimum state requirements.

Benefits payable under this Amendment are reduced to the extent that benefits are payable for the same expenses under the Medical Benefit or Outpatient Prescription Drug Benefit, if applicable.

The provisions on the following pages form part of this Certificate Amendment.

All other terms and conditions shown in Your Certificate of Insurance will continue to apply.

HEALTH NET LIFE INSURANCE COMPANY



Steven Sell

President

1. The **Additional Services and Supplies** subsection of the Medical Benefit section of Your Certificate of Insurance is revised to ~~delete~~ **Mammography** and **Screening and Diagnosis of Prostate Cancer** from **Preventive Care for Adults** and *substitute* the following:

Mammography. For screening purposes in women, for the presence of occult breast cancer. One baseline low dose mammogram for women between the ages of 35 and 39, and an annual mammogram for women 40 years of age or older.

Prostate Cancer Screening Coverage

An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage on an individual, group, blanket, franchise, or association. Coverage is provided for an annual digital rectal examination and a prostate-specific antigen test for an asymptomatic male aged fifty and over, a black male aged forty and over, and a male aged forty or over with a family history of prostate cancer.

2. The following benefits are added to the Additional Services and Supplies section of Your Certificate. Benefits are in addition to any coverage otherwise payable under the Medical Benefit.

Off-Label Prescription Drug Use

1. If coverage is provided for prescription drugs under the Medical Benefit or the Outpatient Prescription Drug Benefit, if applicable, coverage will be provided for prescription drugs for a treatment for which the prescription drug has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific treatment for which it has been prescribed in one of the following established reference compendia:

- a. the American Hospital Formulary Service Drug Information; or
- b. the United States Pharmacopeia Drug Information;

or, it is recommended by a clinical study or review article in a peer-reviewed national medical journal.

2. The coverage required pursuant to this section:

Includes coverage for any Medically Necessary services to administer the drug to the Covered Person.

Does not include coverage for any:

- drug which is deemed Experimental or if Investigational; or
- use of a drug that is contraindicated by the Food and Drug Administration for the treatment for which it is prescribed.

Temporomandibular Joint Disorder Coverage

Coverage is provided for Medically Necessary surgical and non-surgical treatment of temporomandibular joint disorder or craniomandibular joint disorder by a Physician, including a dentist, professionally qualified by training and experience and for Medically Necessary surgery for the correction of functional deformities of maxilla and mandible.

Coverage is limited to a lifetime maximum of \$10,000 for surgical treatment and \$2,500 for non-surgical treatment.

General Anesthesia In Conjunction with Dental Care

Coverage is provided for general anesthesia and associated Hospital or Ambulatory Surgical Center charges in conjunction with dental care provided to a Covered Person insured if such Covered Person is:

1. Eight years of age or younger or is developmentally disabled; or
2. An individual for which a successful result cannot be expected from dental care provided under local anesthesia because of a neurological or other medically compromising condition of the Covered Person.

Payment will be reduced if Certification is not obtained.

Medical Foods and Low Protein Modified Food Products for Therapeutic Treatment of Inherited Metabolic Disease

Coverage is provided for medical foods and low-protein modified food products determined by a Physician to be Medically Necessary for the therapeutic treatment of an inherited metabolic disease, up to a maximum of \$3,000 each Calendar Year.

“Inherited metabolic disease” means maple syrup urine disease or phenylketonuria.

“Low-protein modified food product” means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease. The term does not include a natural food that is naturally low in protein.

“Medical food” means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered under the direction of a Physician.

Coverage is not provided under the plan for low protein modified food products or medical food for a Covered Person to the extent those benefits are available to that Covered Person under a North Dakota department of health or department of human services program.

CERTIFICATE AMENDMENT

to the Certificate of Insurance

For: Covered Persons residing in Oregon

Your Certificate of Insurance is amended to conform to the requirements of the state of Oregon.

Any limitations and exclusions contained in Your Certificate of Insurance which are in conflict with these requirements are hereby amended to comply with the minimum state requirements.

Benefits payable under this Amendment are reduced to the extent that benefits are payable for the same expenses under the Medical Benefit or Outpatient Prescription Drug Benefit, if applicable.

The provisions on the following pages form part of this Certificate Amendment.

All other terms and conditions shown in Your Certificate of Insurance will continue to apply.

HEALTH NET LIFE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read "S. Sell", is positioned above the printed name and title.

Steven Sell

President

1. The **Treatment of Non-Severe Mental Disorders** and **Treatment for Chemical Dependency** sections of the SCHEDULE OF BENEFITS of Your Certificate are deleted and *replaced* with the following:

Mental Illness/and Chemical Dependency

Coverage shall be provided on the same basis as any other illness, subject to the maximums shown in the Medical Benefit section of the Certificate.

2. The **Additional Services and Supplies** subsection of the Medical Benefit section of Your Certificate of Insurance is revised to add the following benefit:

Coverage for Treatment of Inborn Errors of Metabolism

Coverage is provided for the treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism and for which medically standard methods of diagnosis, treatment, and monitoring exist.

Coverage includes expenses of diagnosing, monitoring, and controlling the disorders by nutritional and medical assessment, including but not limited to clinical services, biochemical analysis, medical supplies, prescription drugs, corrective lenses for conditions related to the inborn error of metabolism, nutritional management, and medical foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

“Medical foods” means nutritional substances in any form that are:

- (i). formulated to be consumed or administered externally under supervision of a Physician;
- (ii). specifically processed or formulated to be distinct in one or more nutrients present in natural food;
- (iii). intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and
- (iv). essential to optimize growth, health, and metabolic homeostasis.

“Treatment” means licensed professional medical services under the supervision of a Physician.

3. The **Additional Services and Supplies** subsection of the Medical Benefit section of Your Certificate of Insurance is revised to add the following to “Diabetic Equipment”:

Coverage is also provided under this benefit for Covered Persons for the treatment of insulin-dependent diabetes.

4. The following benefits are added to the **Additional Services and Supplies** subsection of the Medical Benefit section of Your Certificate. These benefits are in addition to any coverage otherwise payable under the Medical Benefit, or Outpatient Prescription Drug Benefit.

Mastectomy and Breast Cancer Treatment

Benefits are payable for Medically Necessary inpatient care following a mastectomy, lumpectomy or a lymph node dissection for the treatment of breast cancer, for the period of time determined by the attending Physician, in consultation with the patient.

Clinical Breast Examination

Benefits are payable for complete and thorough physical examinations of the breast, including but not limited to a clinical breast examination, performed by a health care provider to check for lumps and other changes for the purpose of early detection and prevention of breast cancer as follows:

- a. Annually for women 18 years of age and older; and
- b. At any time at the recommendation of the woman's health care provider.

Off-Label Prescription Drug Use

1. If coverage is provided under the Medical Benefit or the Outpatient Prescription Drug Benefit, if applicable, coverage will be provided for prescription drugs for a treatment for which the prescription drug has not been approved by the Food and Drug Administration if the Oregon Health Resources Commission determines that the drug is recognized as being medically appropriate for the specific treatment for which it has been prescribed in publications that the Commission determines to be equivalent to:
 - a. The American Hospital Formulary Services drug information;
 - b. "Drug Facts and Comparisons" (Lippincott-Raven Publishers);
 - c. the United States Pharmacopeia drug information; or
 - d. Other publications that have been identified by the United States Secretary of Health and Human Services as authoritative;
 - e. In the majority of relevant peer-reviewed medical literature; or
 - f. By the United States Secretary of Health and Human Services.
2. The coverage required pursuant to this section:
 - a. Includes coverage for any Medically Necessary services to administer the drug to the Covered Person.
 - b. Does not include coverage for any:
 - drug which is deemed Experimental or if Investigational; or
 - use of a drug that is contraindicated by the Food and Drug Administration for the treatment for which it is prescribed.

"Peer-reviewed medical literature" means scientific studies printed in journals or other publications that publish original manuscripts only after the manuscripts have been critically reviewed by unbiased independent experts for scientific accuracy, validity and reliability. "Peer-reviewed medical literature" does not include internal publications of pharmaceutical manufacturers.

Maxillofacial Prosthetic Services Coverage

Coverage is provided for maxillofacial prosthetic services which are Medically Necessary for adjunctive treatment including restoration and management of head and facial structures that cannot be replaced with living tissue and that are defective because of disease, trauma or birth and developmental deformities when such restoration and management are performed for the purpose of:

- a. Controlling or eliminating infection;
- b. Controlling or eliminating pain; or
- c. Restoring facial configuration or functions such as speech, swallowing or chewing but not including cosmetic procedures rendered to improve on the normal range of conditions.

Colorectal Cancer Screenings & Examinations & Laboratory Tests

Coverage is provided for an insured 50 years of age or older:

- a. One fecal occult blood test per year plus one flexible sigmoidoscopy every five years;
- b. One colonoscopy every 10 years;
- c. One double contrast barium enema every 5 years;
- d. For an insured who is at high risk for colorectal cancer, colorectal cancer screening examinations and laboratory tests as recommended by the treating physician;
- e. An individual is considered to be at high risk for colorectal cancer if the individual has:
 - A family medical history of colorectal cancer;
 - A prior occurrence of cancer or precursor neoplastic polyps;
 - A prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease or ulcerative colitis; or
 - Other predisposing factors.

Prosthetic and Orthotic Devices

- (1). Coverage is provided for prosthetic and orthotic devices that are Medically Necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that are not solely for comfort or convenience. The coverage includes all services and supplies Medically Necessary for the effective use of a prosthetic or orthotic device, including formulating its design, fabrication, material and component selection, measurements, fittings, static and dynamic alignments, and instructing the patient in the use of the device.
 - (2). As used herein:
 - (a) "Orthotic device" means a rigid or semirigid device supporting a weak or deformed leg, foot, arm, hand, back or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back or neck.
 - (b) "Prosthetic device" means an artificial limb device or appliance designed to replace in whole or in part an arm or a leg.
 - (3). The Director of the Oregon Department of Consumer and Business Services shall adopt and annually update rules listing the prosthetic and orthotic devices covered under this benefit. The list shall be no more restrictive than the list of prosthetic and orthotic devices and supplies in the Medicare fee schedule for Durable Medical Equipment, Prosthetics, Orthotics and Supplies, but only to the extent consistent with this benefit.
 - (4). The coverage for prosthetic and orthotic devices will be paid on the same basis as any other illness.
 - (5). The coverage includes any repair or replacement of a prosthetic or orthotic device that is determined Medically Necessary to restore or maintain the ability to complete activities or daily living or essential job-related activities and that is not solely for comfort or convenience.
5. Benefits for "Services for Non-Severe Mental Disorders", "Serious Emotional Disturbances of a Child" and "Chemical Dependency Services" under the Medical Benefit section of Your Certificate are deleted and *replaced* with the following:

MENTAL ILLNESS AND CHEMICAL DEPENDENCY BENEFITS

Benefits for Mental Illness and Chemical Dependency services will be paid on the same basis as any other illness. The following apply to coverage for chemical dependency and for mental or nervous conditions:

As used in this provision:

- (a) “Chemical Dependency” means the addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with the individual's social, psychological or physical adjustment to common problems. For purposes of this section, “Chemical Dependency” does not include addiction to, or dependency on, tobacco, tobacco products or foods.
- (b) “Facility” means a corporate or governmental entity or other provider of services for the treatment of Chemical Dependency or for the treatment of mental or nervous conditions.
- (c) “Program” means a particular type or level of service that is organizationally distinct within a facility.
- (d) “Provider” means a person that has met Our credentialing requirement, is otherwise eligible to receive reimbursement for coverage under the Group Policy and is:
 - (A) A health care facility;
 - (B) A residential program or facility;
 - (C) A day or partial hospitalization program;
 - (D) An outpatient service; or
 - (E) An individual behavioral health or medical professional authorized for reimbursement under Oregon law.

Coverage will be made subject to provisions of the Group Policy that apply to other benefits under the Group Policy, including but not limited to provisions relating to Deductibles and Coinsurance. Deductibles and Coinsurance for treatment in health care facilities or residential programs or facilities will be the same as those for expenses of hospitalization in the treatment of other medical conditions. Deductibles and Coinsurance for outpatient treatment will be the same than those for expenses of outpatient treatment of other medical conditions.

Coverage will be subject to the same treatment limitations, limits on total payments for treatment, limits on duration of treatment or financial requirements as those limitations or requirements that are imposed on coverage of other medical conditions. The coverage of eligible expenses will be limited to treatment that is Medically Necessary as determined under the Group Policy for other medical conditions.

Coverage is not provided for:

- (A) Educational or correctional services or sheltered living provided by a school or halfway house;
- (B) A long-term residential mental health program that lasts longer than 45 days;
- (C) Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present;
- (D) A court-ordered sex offender treatment program; or
- (E) A screening interview or treatment program under ORS 813.021.

However, a Covered Person may receive covered outpatient services under the terms of the Group Policy while he or she is living temporarily in a sheltered living situation.

A provider is eligible for reimbursement under this section if:

- (a) The provider is approved by the Oregon Department of Human Services;

- (b) The provider is accredited for the particular level of care for which reimbursement is being requested by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities;
- (c) The patient is staying overnight at the facility and is involved in a structured program at least eight hours per day, five days per week; or
- (d) The provider is providing a covered benefit under the Group Policy.

Payments will not be made under this section for support groups.

Coverage for Mental Illness and Chemical Dependency is subject to Certification Requirements contained in Your Certificate.

6. The **Definitions** section of Your Certificate is revised to delete the definition entitled **Emergency Care**, and to *add* the following:

Emergency Care means Medically Necessary services required for a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy.

CERTIFICATE AMENDMENT

to the Certificate of Insurance

For: Covered Persons residing in Pennsylvania

Your Certificate of Insurance is amended to conform to the requirements of the state of Pennsylvania.

Any limitations and exclusions contained in Your Certificate of Insurance which are in conflict with these requirements are hereby amended to comply with the minimum state requirements.

Benefits payable under this Amendment are reduced to the extent that benefits are payable for the same expenses under the Medical Benefit or Outpatient Prescription Drug Benefit, if applicable.

The provisions on the following pages form part of this Certificate Amendment.

All other terms and conditions shown in Your Certificate of Insurance will continue to apply.

HEALTH NET LIFE INSURANCE COMPANY



Steven Sell

President

The **Deductibles** subsection of the SCHEDULE OF BENEFITS section of Your Certificate is revised to add the following:

1. The Calendar Year Deductible does not apply to Covered Expenses incurred for Medically Necessary nutritional supplements (formulas) for the therapeutic treatment of phenylketonuria, branched-chain ketosuria, galactosemia and homocystinuria administered under the direction of a Physician.
2. The **Treatment of Non-Severe Mental Disorders** and **Treatment for Chemical Dependency** sections of the SCHEDULE OF BENEFITS of Your Certificate are deleted and *replaced* with the following:

Mental Disorders

Number of days Inpatient Hospital Services per Calendar Year.....	30
For each inpatient or outpatient Physician visit	\$25
Number of Physician’s visits during a Calendar Year	50

Note: The maximum amount of Covered Expenses for each day in the Hospital is \$175.

Substance Abuse

Inpatient Detoxification

Maximum benefit per lifetime.....	4 separate admissions subject to a maximum of 7 days of inpatient treatment per admission
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Non-Hospital Residential Care

Maximum benefit per Calendar Year	30 days of care
Maximum benefit per lifetime.....	90 days of care

Outpatient Care in a licensed facility

Maximum benefit for Calendar Year	30 full session visits or equivalent partial visits
Maximum benefit per lifetime.....	120 full session visits or equivalent partial visits

In addition, coverage is provided for a maximum of 30 separate sessions of outpatient or partial hospitalization services per Calendar Year, which may be exchanged on a two-to-one basis to secure up to fifteen additional non-hospital, residential alcohol treatment days.

3. The following is added to the SCHEDULE OF BENEFITS section of Your Certificate:

Serious Mental Illness/Serious Emotional Disturbances

Coverage shall be provided on the same basis as any other illness subject to a maximum of 30 inpatient days and 60 outpatient days of confinement during a Calendar Year. A Covered Person may convert coverage of inpatient days to outpatient days on a one-for-two basis.

4. The definition entitled **Emergency Care** in the DEFINITIONS section of Your Certificate is *replaced* with the following definition:

Emergency Care means Medically Necessary services required to treat a medical condition with Acute symptoms of severity or severe pain for which:

1. care is sought as soon as possible after the medical condition becomes evident to the patient or the patient's parent or guardian; and
2. the absence of immediate medical attention could result in:
 - a. placing health in serious jeopardy;
 - b. serious impairment to bodily functions;
 - c. serious dysfunction of any body part; or
 - d. other severe medical consequences.

5. The **Additional Services and Supplies** subsection of the Medical Benefit section of Your Certificate is *revised* to:

- (a) *add* the following to **Preventive Care for Adults**:

Routine pap smears will be provided in accordance with the recommendations of the American College of Obstetricians and Gynecologists.

- (b) *delete* **Mammography** and *replace* it with the following:

Mammography – one mammogram per Calendar Year for women 40 years of age or older and any mammogram based on a Physician's recommendation for women under 40 years of age. Mammograms will be provided by a screening mammography provider, properly licensed under the Pennsylvania Mammography Quality Assurance Act.

- (c) *add* the following Covered Expense:

Branched-chain Ketonuria, Galactosemia and Homocystinuria Testing and Treatment.

Coverage is provided for the testing and treatment of branched-chain ketonuria, galactosemia and homocystinuria on the same basis as testing and treatment of phenylketonuria (PKU).

- (d) *add* the following Covered Expense:

Mastectomy Coverage

Benefits are payable for 48 hours of inpatient care following a mastectomy or a longer period if such care is recommended by the Covered Person's treating Physician, after conferring with the Covered Person. A Covered Person is not required to have mastectomy surgery on an outpatient basis.

- (e) *add* the following Covered Expense:

Autism Spectrum Disorders

Coverage is provided to Covered Persons under 21 years of age for the diagnostic assessment of autism spectrum disorders and for the treatment of autism spectrum disorders.

Coverage is subject to a maximum benefit of \$36,000 per Calendar Year but is not subject to any limits on the number of visits to an autism service provider for treatment of autism spectrum disorders.

As used above:

- (1) “Applied behavioral analysis” means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.
- (2) “Autism service provider” means any of the following:
 - (i) A person, entity or group providing treatment of autism spectrum disorders, pursuant to a treatment plan, that is licensed or certified in the Commonwealth of Pennsylvania.
 - (ii) Any person, entity or group providing treatment of autism spectrum disorders, pursuant to a treatment plan, that is enrolled in the Commonwealth of Pennsylvania’s medical assistance program on or before July 1, 2009.
- (3) “Autism spectrum disorders” means any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or its successor, including autistic disorder, Asperger’s disorder and pervasive developmental disorder not otherwise specified.

(f) *add* the following Covered Expense:

Colorectal Cancer Screening

Coverage is provided for colorectal cancer screening for Covered Persons in accordance with American Cancer Society guidelines for colorectal cancer screening and consistent with approved medical standards and practices.

- (1) Coverage for nonsymptomatic Covered Persons who are fifty (50) years of age or older includes but is not limited to:
 - (i) An annual fecal occult blood test.
 - (ii) A sigmoidoscopy, a screening barium enema or a test consistent with approved medical standards and practices to detect colon cancer, at least once every five (5) years.
 - (iii) A colonoscopy at least once every ten (10) years.
- (2) Coverage for symptomatic Covered Persons includes a colonoscopy, sigmoidoscopy or any combination of colorectal cancer screening tests at a frequency determined by a treating Physician.
- (3) Coverage for nonsymptomatic Covered Persons who are at high or increased risk for colorectal cancer who are under 50 years of age includes a colonoscopy or any combination of colorectal cancer screening tests in accordance with the American Cancer Society guidelines on screening for colorectal cancer published as of January 1, 2008.

CERTIFICATE AMENDMENT

to the Certificate of Insurance

For: Covered Persons residing in South Carolina

Your Certificate of Insurance is amended to conform to the requirements of the state of South Carolina.

Any limitations and exclusions contained in Your Certificate of Insurance which are in conflict with these requirements are hereby amended to comply with the minimum state requirements.

Benefits payable under this Amendment are reduced to the extent that benefits are payable for the same expenses under the Medical Benefit or Outpatient Prescription Drug Benefit, if applicable.

The provisions on the following pages form part of this Certificate Amendment.

All other terms and conditions shown in Your Certificate of Insurance will continue to apply.

HEALTH NET LIFE INSURANCE COMPANY



Steven Sell

President

1. The **Additional Services and Supplies** subsection of the Medical Benefit section of Your Certificate of Insurance is revised to add the following to “Diabetic Equipment”:

Coverage is also provided under this benefit for Covered Persons for Food and Drug Administration-approved medication indicated for the treatment of diabetes.

2. The following benefits are added to the **Additional Services and Supplies** section of Your Certificate. These benefits are in addition to any coverage otherwise payable under the Medical Benefit, or Outpatient Prescription Drug Benefit.

Mastectomy and Breast Cancer Treatment

Benefits are payable for 48 hours of Medically Necessary inpatient care following a mastectomy. In the case of an early release, coverage will include one home care visit if ordered by the attending Physician.

Treatment of Cleft Lip and Cleft Palate

Benefits are payable for a covered newborn child born with a cleft lip, cleft palate, or both, including the following:

- 1) oral and facial surgery, surgical management, and follow-up care by plastic surgeons and oral surgeons;
- 2) prosthetic treatment such as obturators, speech appliances and feeding appliances;
- 3) Medically Necessary orthodontic treatment and management;
- 4) Medically Necessary prosthodontic treatment and management;
- 5) Medically Necessary physical therapy assessment and treatment;
- 6) otolaryngology treatment; and
- 7) audiological assessments and treatment.

The services may be provided on an inpatient or outpatient basis and will have no age limit.

If the person:

- a. is covered under any other group policy or plan for dental care benefits, the benefits payable for teeth capping, prosthodontics and orthodontic treatment will be payable under the dental plan. This will be the case even if orthodontia is not covered under the dental plan.
- b. is not covered under any other group policy or plan for dental care benefits, then the benefits payable for teeth capping, prosthodontics and orthodontic treatment will be payable under this plan.

Benefits will be payable on the same basis as any other illness, and will also be payable for any conditions or illness which is related to or developed as a result of the cleft lip or cleft palate.

Benefits will not be payable under this section for dental or orthodontic treatment unrelated to the management of cleft lip and cleft palate.

Off-Label Prescription Drug Use

1. If coverage is provided under the Medical Benefit or the Outpatient Prescription Drug Benefit, if applicable, coverage will be provided for prescription drugs for cancer treatment for which the prescription drug has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific treatment for which it has been prescribed in one of the following established reference compendia:
 - a. the American Medical Association Drug Evaluations;
 - b. the American Hospital Formulary Service Drug Information;
 - c. the United States Pharmacopeia Drug Information;or, it is recommended in two articles from major peer-reviewed professional medical journals that have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which it has been prescribed unless one article from major peer-reviewed professional medical journals has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed.
2. The coverage required pursuant to this section:
 - a. Includes coverage for any Medically Necessary services to administer the drug to the Covered Person.
 - b. Does not include coverage for any:
 - drug which is deemed Experimental or if Investigational; or
 - use of a drug that is contraindicated by the Food and Drug Administration for the treatment for which it is prescribed.
3. Benefits for "Services for Severe Mental Illness" and "Serious Emotional Disturbances of a Child" under the Medical Benefit section of Your Certificate are deleted and *replaced* by the following:

COVERAGE FOR MENTAL DISORDERS

Coverage is provided for treatment of a mental health condition on the same basis as any other illness, including application of any Deductible or Coinsurance and Out of Pocket amounts.

To be eligible for coverage under this Certificate for the treatment of Mental Illness, the treatment must be rendered by a licensed Physician, licensed mental health professional, or certified mental health professional in a mental health facility that provides a program for the treatment of a mental health condition pursuant to a written treatment plan. A mental health facility, licensed Physician, or licensed or certified mental health professional may be required by Us, to enter into a contract as a condition of providing benefits.

"Mental health condition" means the following psychiatric illnesses as defined by the "Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV)", and subsequent editions published by the American Psychiatric Association:

- a. Bipolar Disorder;
- b. Major Depressive Disorder;
- c. Obsessive Compulsive Disorder;
- d. Paranoid and Other Psychotic Disorder;
- e. Schizoaffective Disorder;
- f. Schizophrenia;
- g. Anxiety Disorder;
- h. Post-traumatic Stress Disorder; and
- i. Depression in childhood and adolescence.

CERTIFICATE AMENDMENT

to the Certificate of Insurance

For: Covered Persons residing in South Dakota

Your Certificate of Insurance is amended to conform to the requirements of the state of South Dakota.

Any limitations and exclusions contained in your Certificate of Insurance which are in conflict with these requirements are hereby amended to comply with the minimum state requirements.

Benefits payable under this Amendment are reduced to the extent that benefits are payable for the same expenses under the Medical Benefit or Outpatient Prescription Drug Benefit, if applicable.

The provisions on the following pages form part of this Certificate Amendment.

All other terms and conditions shown in your Certificate of Insurance will continue to apply.

HEALTH NET LIFE INSURANCE COMPANY



Steven Sell

President

1. The **Age Limit for Children** subsection of the ELIGIBILITY, ENROLLMENT AND TERMINATION section of Your Certificate is amended to *add* the following provision:

Age Limit for Children

If the Dependent Child remains a full-time student upon attaining age 24, but not beyond age 29, coverage can be continued at the option of the Covered Person. The Employer is not required to contribute any portion of the premium required to continue this coverage for full-time students who have attained age 24. This continuation of coverage does not apply to any qualifying relative, whose gross income is less than the exemption amount prescribed by the South Dakota Administrative and Rules Code.

Continuation of coverage for full-time students attaining age 24 is not available if the child has other Creditable Coverage in force.

2. The **Additional Services and Supplies** subsection of the Medical Benefit section of your Certificate of Insurance is revised to delete "Diabetic Equipment" and to *substitute* the following:

Diabetes Coverage

Covered Services and Supplies include Covered Expenses for equipment, supplies, medication and outpatient self-management training and patient management including medical nutrition therapy for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a health care professional legally authorized by law to prescribe such items.

The equipment, supplies, medication, and patient management for the use of the equipment, supplies, and medication listed herein are included:

- blood glucose monitors;
- blood glucose monitors for the legally blind;
- test strips for glucose monitors;
- urine testing strips;
- insulin;
- injection aids;
- lancet and lancet devices;
- syringes;
- insulin pumps and all supplies for the pump;
- insulin infusion devices;
- oral agents for controlling blood sugars;
- glucose agents and glucagon kits;
- insulin measurement and administration aids for the visually impaired;
- patient management materials that provide essential diabetes self-management information; and
- podiatric appliances for the prevention of complications associated with diabetes.

Coverage is provided for the patient upon the diagnosis of diabetes, when a significant change occurs in the patient's symptoms or condition that necessitates changes in a patient's self-management, or when refresher patient management is necessary. The benefits cover home visits when Medically Necessary and prescribed by a health care professional legally authorized by law to prescribe such items. Patient management may be conducted individually or in a group setting as long as there is Medical Necessity.

Diabetes self-management training and patient management, including medical nutrition therapy, must be based upon a diabetes program recognized by the American Diabetes Association or a diabetes program with a curriculum approved by the American Diabetes Association or the South Dakota Department of Health.

Physician-prescribed diabetes self-management training and patient management will be covered at diagnosis, when symptoms or conditions change, and when new medications or treatments are prescribed. Diabetes self-management education must be deemed to be Medically Necessary by a Physician to be eligible for coverage.

Benefits for diabetes coverage are subject to the Deductible and applicable Coinsurance and Exclusions and Limitations.

3. The following benefits are added to the **Additional Services and Supplies** section of your Certificate. These benefits are in addition to any coverage otherwise payable under the Medical Benefit, or Outpatient Prescription Drug Benefit.

General Anesthesia In Conjunction with Dental Care

Coverage is provided for general anesthesia and associated Hospital or Ambulatory Surgical Center charges in conjunction with dental care provided to a Covered Person insured if such Covered Person:

1. Is a child under age five; or
2. Is severely disabled or otherwise suffers from a developmental disability as determined by a licensed Physician which places such person at serious risk.

Payment of Benefits for general anesthesia in connection with dental care will be reduced if Certification is not obtained for the general anesthesia.

Prostate Cancer Screening Coverage

Coverage is provided for an annual medically recognized diagnostic examination for the detection of prostate cancer of a male Covered Person. Coverage includes:

- a. a physical examination for the detection of prostate cancer; and
- b. a prostate-specific antigen test used for the detection of prostate cancer for each male Covered Person who is:
 - (1) at least 50 years of age;
 - (2) at least 45 years of age and symptomatic, or with a family history of prostate cancer or another prostate cancer risk factor; or
 - (3) any age with a prior history of prostate cancer.

Off-Label Prescription Drug Use

If coverage is provided for prescription drug charges under the Medical Benefit or the Outpatient Prescription Drug Benefit, if applicable, coverage will be provided prescription drugs for a treatment for which the prescription drug has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific treatment for which it has been prescribed in at least one standard reference compendia or in medical literature.

CERTIFICATE AMENDMENT

to the Certificate of Insurance

For: Covered Persons residing in Texas

Your Certificate of Insurance is amended to conform to the requirements of the state of Texas.

Any limitations and exclusions contained in Your Certificate of Insurance which are in conflict with these requirements are hereby amended to comply with the minimum state requirements.

Benefits payable under this Amendment are reduced to the extent that benefits are payable for the same expenses under the Medical Benefit or Outpatient Prescription Drug Benefit, if applicable.

The provisions on the following pages form part of this Certificate Amendment.

All other terms and conditions shown in Your Certificate of Insurance will continue to apply.

HEALTH NET LIFE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read "S. Sell", is positioned above the printed name and title.

Steven Sell

President

1. The **Treatment of Non-Severe Mental Disorders** and **Treatment for Chemical Dependency** sections of the SCHEDULE OF BENEFITS of Your Certificate are deleted and *replaced* with the following:

Mental Disorders

Number of days Inpatient Hospital Services per Calendar Year.....	45
Number of days partial Hospital Services per Calendar Year.....	90

Substance Abuse

Coverage shall be provided on the same basis as any other illness subject to a maximum of three series of treatments during a Covered Person’s lifetime.

2. The **When Coverage Ends** subsection of the ELIGIBILITY, ENROLLMENT AND TERMINATION section of Your Certificate is amended to delete the first paragraph and *replace* it with the following:

You must notify the Group of changes that will affect Your eligibility. The Group will send the appropriate request to HNL according to current procedures. HNL is not obligated to notify You that You are no longer eligible or that Your coverage has been terminated. The Group is liable for Your premium from the time You are no longer part of the Group until the end of the month in which the Group notifies HNL that You are no longer part of the Group. You will remain covered under the Policy until the end of that period.

3. The **Age Limit for Children** subsection of the ELIGIBILITY, ENROLLMENT AND TERMINATION section of Your Certificate is *replaced* with the following:

Age Limit for Children

Each unmarried child is eligible until age 25 (the limiting age). However, unmarried children who are enrolled as Full-Time students at an accredited college or university will be eligible for coverage for an entire academic term during which the child begins as a Full-Time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child’s academic status to less than that of a Full-Time student. Additionally, coverage will be provided continuously until the 10th day of instruction of the subsequent academic term on which date coverage of the child will terminate if the child does not return to Full-Time student status before that date.

4. The benefits for “Services for Non-Severe Mental Disorders” and “Chemical Dependency Services” under the Medical Benefit section of Your Certificate are deleted and *replaced* with the following:

Services for Mental Disorders. Covered Services for the treatment of Mental Disorders, including autism are limited as follows:

- a. Charges incurred as an inpatient in a Hospital or a psychiatric Hospital will be covered for up to 45 days in a Calendar Year.
- b. Charges incurred for partial hospitalization in a Hospital or psychiatric Hospital will be covered for up to 90 days in a Calendar Year. Partial hospitalization means a continuous treatment for at least 3 hours but not more than 12 hours in any 24-hour period. Each 2 days of partial hospitalization care will reduce by one day the 45 days available for inpatient care,

and each day of inpatient care will reduce by 2 days the 90 days available for partial hospitalization care.

- c. Charges incurred for outpatient treatment will be payable for services furnished by a comprehensive health care service corporation, a Hospital or a community mental health center or other mental health clinics approved to provide such mental health services; or furnished by a registered professional nurse; or furnished by a licensed clinical social worker; or furnished by a licensed professional counselor; or furnished by or under the supervision of a licensed Physician or licensed psychologist.
- d. Covered Expenses for inpatient recognized Mental Illness will also include Covered Expenses in a Psychiatric Day Treatment Facility or in a Residential Treatment Center for Children and Adolescents or from a Crisis Stabilization Unit. Benefits payable for care in a Residential Treatment Center for Children or Adolescents or a Crisis Stabilization Unit are subject to the following:
 - 1. The Covered Person must have a serious mental illness which substantially impairs the Covered Person's thought, perception of reality, emotional process or judgment, or grossly impairs behavior as manifested by recent disturbed behavior and which would otherwise necessitate confinement in a Hospital if such care and treatment were not available through a crisis stabilization unit or residential treatment center for children and adolescents; and
 - 2. The services rendered must be based on an individual treatment plan; and
 - 3. Providers of services must be licensed or operated by the appropriate state agency or board to provide those services.

Each full day of treatment in a Psychiatric Day Treatment Facility will reduce by one-half day the 45 days available for inpatient care. Each 2 days of treatment in a Residential Treatment Center for Children and Adolescents or treatment in a Crisis Stabilization Unit will reduce by one day the 45 days available for inpatient care.

As used above, "Crisis Stabilization Unit" means a 24-hour residential program that is usually short-term in nature and that provides intensive supervision and highly structured activities to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

"Individual treatment plan" means a treatment plan with specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

"Psychiatric Day Treatment Facility" means a mental health facility accredited by the Program for Psychiatric Facilities, or its successor, of the Joint Commission on Accreditation of Hospitals. Such facility must provide treatment for individuals suffering from acute mental and nervous disorders in a structured psychiatric program utilizing individual treatment plans with specific attainable goals and objectives appropriate both to the patient and the treatment modality of the program. The facility must be clinically supervised by a doctor of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology.

"Residential Treatment Center for Children and Adolescents" means a child-care institution that provides residential care and treatment of emotionally disturbed children and

adolescents and that is accredited as a residential treatment center by the Council on Accreditation, the Joint Commission on Accreditation of Hospitals, or the American Association of Psychiatric Services for Children.

Substance Abuse Services. Expenses incurred for substance abuse will include treatment in a chemical treatment facility as long as the facility provides a program for the treatment of chemical dependency pursuant to a written treatment plan approved and monitored by a Physician and such facility is also:

- a. affiliated with a Hospital under a contractual agreement with an established system for patient referral; or
- b. accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or
- c. licensed as a chemical treatment program by the Texas Commission on Alcohol and Drug Abuse; or
- d. licensed, certified or approved as a chemical dependency treatment program or center by any other Texas state agency having legal authority to so license, certify or approve.

Coverage for substance abuse is limited to a lifetime maximum of three separate “series of treatments” for each Covered Person. A “series of treatment” is a planned, structured, and organized program to promote chemical free status which may include different facilities or modalities and is complete when the Covered Person is discharged on medical advice from inpatient detoxification, inpatient rehabilitation/treatment, partial hospitalization or intensive outpatient or a series of these levels of treatments without a lapse in treatment or when a person fails to materially comply with the treatment program for a period of 30 days.

“Psychiatric Day Treatment Facility” means a mental health facility accredited by the Program for Psychiatric Facilities, or its successor, of the Joint Commission on Accreditation of Hospitals. Such facility must provide treatment for individuals suffering from acute mental and nervous disorders in a structured psychiatric program utilizing individual treatment plans with specific attainable goals and objectives appropriate both to the patient and the treatment modality of the program. The facility must be clinically supervised by a doctor of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology.

“Residential Treatment Center for Children and Adolescents” means a child-care institution that provides residential care and treatment of emotionally disturbed children and adolescents and that is accredited as a residential treatment center by the Council on Accreditation, the Joint Commission on Accreditation of Hospitals, or the American Association of Psychiatric Services for Children.

5. The following benefits are *added* to the **Additional Services and Supplies** section of the Medical Benefit section of Your Certificate. These benefits are in addition to any coverage otherwise payable under the Medical Benefit.

Autism Spectrum Disorder for certain children

Coverage is provided to a Covered Person older than two years of age, and younger than six years of age who is diagnosed with autism spectrum disorder. If a Covered Person who is being treated for autism spectrum disorder becomes six years of age or older and continues to need treatment, coverage will include all generally recognized services prescribed in relation to autism spectrum disorder by the Covered Person's physician in the treatment plan recommended by that Physician. An individual providing treatment prescribed herein must be a health care practitioner:

- (1) who is licensed, certified, or registered by an appropriate agency of this state;
- (2) whose professional credential is recognized and accepted by an appropriate agency of the United States; or
- (3) who is certified as a provider under the TRICARE military health system.

"Generally recognized services" includes services such as:

- (1) evaluation and assessment services;
- (2) applied behavior analysis;
- (3) behavior training and behavior management;
- (4) speech therapy;
- (5) occupational therapy;
- (6) physical therapy; or
- (7) medications or nutritional supplements used to address symptoms of autism spectrum disorder.

Mammographic Examinations

An annual mammographic screening examination for female Covered Persons 35 years of age or older will be treated as Covered Services under the Medical Benefit.

For the purpose of this provision, "mammographic screening" means the X-ray examination of the breast for the presence of occult breast cancer, using equipment dedicated specifically for mammography, including the X-ray tube, filter, compression device, screen, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast and two views for each breast.

Temporomandibular Joint Disorder (TMJ)

Charges for Medically Necessary medical services for the diagnosis and treatment (surgical and non-surgical) of conditions affecting Temporomandibular Joint Disorder (TMJ) and Craniomandibular Disorders are eligible for coverage as any other illness, subject to the Deductible, applicable Coinsurance and Exclusions and Limitations of the plan. Excluded from coverage are the following: orthodontic appliances and treatment, crowns, bridges and dentures, except when required as the result of an accident or Injury (other than chewing) to natural teeth while coverage is in force. Coverage under this provision is subject to the Deductible, applicable Coinsurance and Exclusions and Limitations of the plan.

Diabetes Coverage

Covered Services and Supplies include Covered Expenses incurred by a Covered Person who has been diagnosed with insulin dependent diabetes or non-insulin dependent diabetes; with elevated blood glucose levels induced by pregnancy; or with another medical condition associated with elevated blood glucose levels. Coverage for the treatment of diabetes and associated conditions include the following:

- a. Diabetes self-management training programs provided by a certified, registered or licensed health care professional with recent education in diabetes management, including:
 1. training provided to the Covered Person after the initial diagnosis of diabetes in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies;
 2. additional training authorized on the diagnosis of a Physician or other health care practitioner of a significant change in the Covered Person's symptoms or condition that requires changes in the Covered Person's self-management regime; and
 3. periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by the development of new techniques and treatments for diabetes.
- b. Equipment, supplies and appliances to treat diabetes include:
 1. blood glucose monitors, including noninvasive glucose monitors and glucose for the legally blind;
 2. insulin pumps and associated appurtenances;
 3. insulin infusion devices;
 4. podiatric appliances for the prevention of complications associated with diabetes;
 5. test strips for blood glucose monitors;
 6. visual reading and urine test strips;
 7. lancets and lancet devices;
 8. insulin and insulin analogs;
 9. injection aids;
 10. syringes;
 11. prescriptive and nonprescriptive oral agents for controlling blood sugar levels; and
 12. glucagon emergency kits.

Benefits for diabetes coverage are subject to the Deductible and applicable Coinsurance and Exclusions and Limitations of the plan.

Prostate Cancer Coverage

Covered Expenses include Covered Expenses incurred for an annual medically recognized diagnostic examination for the detection of prostate cancer of a male Covered Person. Coverage includes:

- a. a physical examination for the detection of prostate cancer; and
- b. a prostate-specific antigen test used for the detection of prostate cancer for each male Covered Person who is:
 1. at least 50 years of age and asymptomatic; or
 2. at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

Childhood Immunization Coverage

Covered Services include charges incurred for childhood immunization of a covered Dependent child from birth through age 6. Coverage will be provided for immunization against the following:

- a. diphtheria;
- b. hemophilus influenza type b;
- c. hepatitis B;
- d. measles;
- e. mumps;
- f. pertussis;
- g. polio;
- h. rubella;
- i. tetanus;
- j. varicella; and
- k. any other immunization required by law for the child.

Benefits for child immunization are not subject to the Deductible or Coinsurance.

Telemedicine Services

Benefits are payable for services provided through Telemedicine the same as any other illness, subject to the applicable Deductible, Coinsurance or Copayment. For the purpose of this provision, "Telemedicine" means the use of interactive audio, video, or other electronic media to deliver health care. The term includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education. The term does not include services performed using a telephone or facsimile.

Osteoporosis

Benefits are payable for a Covered Person considered a qualified individual for medically accepted bone mass measurement for the detection of low bone mass and to determine the person's risk of osteoporosis and fractures associated with osteoporosis.

For the purpose of this provision, "qualified individual" means:

- a. a postmenopausal woman who is not receiving estrogen replacement therapy;
- b. an individual with:
 1. vertebral abnormalities;
 2. primary hyperparathyroidism; or
 3. a history of bone fractures; or
- c. an individual who is:
 1. receiving long-term glucocorticoid therapy; or
 2. being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

Off-Label Prescription Drug Use

If coverage is provided for prescription drug charges under the Medical Benefit or the Outpatient Prescription Drug Benefit, if applicable, coverage will be provided for prescription drugs for a treatment for which the prescription drug has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific treatment for which it

has been prescribed in at least one standard drug reference compendia, or substantially accepted peer-reviewed medical literature.

The coverage required pursuant to this section:

- a. Includes coverage for any Medically Necessary services to administer the drug to the Covered Person.
- b. Does not include coverage for any:
 - (1) Experimental drug used for the treatment of cancer, if that drug has not been approved by the Food and Drug Administration; or
 - (2) Use of a drug that is contraindicated by the Food and Drug Administration.

Craniofacial Abnormalities

Benefits are payable for reconstructive surgery for craniofacial abnormalities of a Dependent child under age 18 on the same basis as any other reconstructive surgery.

Reconstructive surgery means surgery to:

1. Improve the function of an abnormal structure.
2. Create a normal appearance of an abnormal structure.

The abnormal structure must have been caused by any of the following:

1. Congenital defect.
2. Developmental deformity.
3. Disease.
4. Infection.
5. Trauma.
6. Tumor.

Acquired Brain Injury

Coverage is provided, on the same basis as any other Injury, for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, or community reintegration services necessary as a result of and related to an acquired brain injury.

Coverage includes reasonable expenses related to periodic reevaluation of the care of a Covered Person who: (1) has incurred an acquired brain injury; (2) has been unresponsive to treatment; and (3) becomes responsive to treatment at a later date. A determination of whether expenses are reasonable includes consideration of factors including: (1) cost; (2) the time that has expired since the previous evaluation; (3) any difference in the expertise of the Physician or practitioner performing the evaluation; (4) changes in technology; and (5) advances in medicine.

Colorectal Screening Testing

Coverage is provided for each Covered Person who is 50 years of age or older and at normal risk for developing colon cancer for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer.

Coverage is limited to:

- (a) a fecal occult blood test performed annually; and
- (b) a flexible sigmoidoscopy performed every five years; or
- (c) a colonoscopy performed every 10 years.

Testing for Detection for Human Papillomavirus and Clinical Cancer

Coverage is provided for diagnostic medical procedures for woman 18 years of age or older for expenses for an annual medically recognized diagnostic examination for the early detection of cervical cancer.

Coverage includes a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

A screening test must be performed in accordance with guidelines adopted by:

1. the American College of Obstetricians and Gynecologist; or
2. another similar national organization of medical professionals recognized by the Texas Commissioner of Insurance.

Coverage for Clinical Trials

Coverage is provided for routine patient care costs to a Covered Person in connection with a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of a life-threatening disease or condition and is approved by:

1. the Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
2. the National Institutes of Health;
3. the United States Food and Drug Administration;
4. the United States Department of Defense;
5. the United States Department of Veterans Affairs; or
6. an institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

“Routine patient care costs” means the costs of any Medically Necessary health care service for which benefits are provided under a health benefit plan, without regard to whether the Covered Person is participating in a clinical trial. Routine patient care costs do not include:

- a. the cost of an investigational new drug or device that is not approved for any indication by the United States Food and Drug Administration, including a drug or device that is the subject of the clinical trial;
- b. the cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in a clinical trial;

- c. the cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- d. a cost associated with managing a clinical trial; or
- e. the cost of a health care service that is specifically excluded from coverage under the Certificate of Insurance

Coverage for Prosthetic Devices, Orthotic Devices, and Related Services

Coverage is provided for prosthetic devices, orthotic devices, and professional services related to the fitting and use of those devices that equals the coverage provided under federal laws for health insurance for the aged and disabled under Sections 1832, 1833, and 1834, Social Security Act (42 U.S.C. Sections 139k, 1395l, and 1395m), and 42 C.F.R. Sections 410.100, 414.202, 414.210, and 414.228, as applicable.

Covered benefits are limited to the most appropriate model of prosthetic device or orthotic device that adequately meets the medical needs of the Covered Person as determined by the Covered Person's treating Physician or podiatrist and prosthetist or orthotist, as applicable.

The repair and replacement of a prosthetic device or orthotic device is a covered benefit unless the repair or replacement is necessitated by misuse or loss by the Covered Person.

Coverage specified above:

1. must be provided in a manner determined to be appropriate in consultation with the treating Physician or podiatrist and prosthetist or orthotist, as applicable, and the Covered Person;
2. will be subject to annual deductible, copayments, and coinsurance that are consistent with annual deductibles, copayments, and coinsurance required for other coverage under the health benefit plan; and
3. will not be subject to annual dollar limits.

Covered benefits may be provided by a pharmacy that has employees who are qualified under the Medicare system and applicable Medicaid regulations to service and bill for orthotic services.

CERTIFICATE AMENDMENT

to the Certificate of Insurance

For: Covered Persons residing in West Virginia

Your Certificate of Insurance is amended to conform to the requirements of the state of West Virginia.

Any limitations and exclusions contained in Your Certificate of Insurance which are in conflict with these requirements are hereby amended to comply with the minimum state requirements.

Benefits payable under this Amendment are reduced to the extent that benefits are payable for the same expenses under the Medical Benefit or Outpatient Prescription Drug Benefit, if applicable.

The provisions on the following pages form part of this Certificate Amendment.

All other terms and conditions shown in Your Certificate of Insurance will continue to apply.

HEALTH NET LIFE INSURANCE COMPANY



Steven Sell

President

Dependent means an eligible employee's unmarried child or stepchild under age 25 if the child or stepchild meets the definition of a "qualifying child" or a "qualifying relative" in section 152 of the Internal Revenue Code.

1. The **Age Limit for Children** subsection of the ELIGIBILITY, ENROLLMENT AND TERMINATION section of Your Certificate is *replaced* with the following:

Age Limit for Children

An unmarried child is eligible until age 25 (the limiting age) if that child or stepchild meets the definition of a "qualifying child" or a "qualifying relative" in section 152 of the Internal Revenue Code.

2. The **Additional Services and Supplies** subsection of the Medical Benefit section of Your Certificate of Insurance is revised to delete **Diabetic Equipment** and to *substitute* the following:

Diabetes Coverage

Coverage is provided for the following equipment and supplies for the treatment and/or management of diabetes for both insulin dependent and noninsulin dependent Covered Persons with diabetes and those with gestational diabetes, if Medically Necessary and prescribed by a licensed Physician: Blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar, orthotics and any additional items required by the West Virginia insurance commissioner, with the advice of the West Virginia commissioner of the bureau of public health.

Coverage also includes coverage for diabetes self-management education to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetes, including information on proper diets. Coverage for self-management education and education relating to diet and prescribed by a licensed Physician is limited to: (1) visits Medically Necessary upon the diagnosis of diabetes; (2) visits under circumstances whereby a Physician identifies or diagnoses a significant change in the patient's symptoms or conditions that necessitates changes in a patient's self-management; and (3) where a new medication or therapeutic process relating to the Covered Person's treatment and/or management of diabetes has been identified as Medically Necessary by a licensed Physician: Provided, That coverage for reeducation or refresher education is limited to a Calendar Year Maximum of \$100.

The education may be provided by the Physician as part of an office visit for diabetes diagnosis or treatment, or by a certified diabetes educator certified by a national diabetes educator certification program, or registered dietitian registered by a nationally recognized professional association of dietitians upon the referral a Physician; Provided, That such national diabetes education certification program or nationally recognized professional association of dietitians has been certified to the West Virginia commissioner of insurance by the West Virginia commissioner of the bureau of public health.

3. The **Additional Services and Supplies** subsection of the Medical Benefit is revised to delete **Mammography, Cervical Cancer Screening Test, Pelvic Exam and Breast Exam, and Screening and Diagnosis of Prostate Cancer** under **Preventive Care for Adults**, and *substitute* the following:

Mammography Mammograms when medical appropriate and consistent with the current guidelines from the United States Preventive Services Task Force;

Pap Smear A pap smear, either conventional or liquid-based cytology, whichever is medically appropriate and consistent with the current guidelines from either the United States Preventive Services Task Force or The American College of Obstetricians and Gynecologists, for women age eighteen or over; or

HPV Test A test for the human papilloma virus (HPV), when medically appropriate and consistent with the current guidelines from either the United States Preventive Services Task force or The American College of Obstetricians and Gynecologists, for women age eighteen or over.

4. The **Additional Services and Supplies** subsection of the Medical Benefit is revised to add the following to **Preventive Care For Children**.

This coverage is not subject to any Coinsurance, Deductible or Copayment amount.

5. The **Additional Services and Supplies** subsection of the Medical Benefit is revised to add the following benefit:

Dental Anesthesia Services

Coverage for dental anesthesia services is provided as follows:

For purposes of this benefit, “dental anesthesia services” means general anesthesia for dental procedures and associated outpatient hospital or ambulatory facility charges provided by appropriately licensed health care individuals in conjunction with dental care provided to a Covered Person if the Covered Person is:

- a. Seven years of age or younger or is developmentally disabled and is an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual or other medically compromising condition of the Covered Person and for whom a superior result can be expected from dental care provided under general anesthesia; or
- b. A child who is twelve years of age or younger with documented phobias, or with documented mental illness, and with dental needs of such magnitude that treatment should not be delayed or deferred and for whom lack of treatment can be expected to result in infection, loss of teeth or other increased oral or dental morbidity and for whom a successful result cannot be expected from dental care provided under local anesthesia because of such condition and for whom a superior result can be expected from dental care provided under general anesthesia.

Prior Authorization is required. Please refer to the **Certification** section of Your Certificate of Insurance for details.

5. The **Mental Health Care** subsection of the Medical Benefit section of Your Certificate of Insurance is revised to add “substance-related disorders”, other than caffeine-related disorders and nicotine-related disorders to the listing of “severe mental illnesses”.

CERTIFICATE AMENDMENT

to the Certificate of Insurance

For: Covered Persons residing in Wisconsin

Your Certificate of Insurance is amended to conform to the requirements of the state of Wisconsin.

Any limitations and exclusions contained in Your Certificate of Insurance which are in conflict with these requirements are hereby amended to comply with the minimum state requirements.

Benefits payable under this Amendment are reduced to the extent that benefits are payable for the same expenses under the Medical Benefit or Outpatient Prescription Drug Benefit, if applicable.

The provisions on the following pages form part of this Certificate Amendment.

All other terms and conditions shown in Your Certificate of Insurance will continue to apply.

HEALTH NET LIFE INSURANCE COMPANY



Steven Sell

President

1. The **Treatment of Non-Severe Mental Disorders** and **Treatment for Chemical Dependency** sections of the SCHEDULE OF BENEFITS of Your Certificate are deleted and *replaced* with the following:

Mental Disorders/Substance Abuse

- Number of days Inpatient Hospital Services per Calendar Year30
- subject to a Calendar Year maximum benefit of \$7,000
- Outpatient treatment maximum benefit per Calendar Year\$2,000
- Transitional treatment arrangements maximum benefit per Calendar Year\$3,000

“Transitional treatment arrangements” means services for the treatment of nervous or mental disorders or alcoholism or other drug abuse problems that are provided to a Covered Person in a less restrictive manner than are Inpatient Hospital Services but in a more intensive manner than are outpatient services.

Coverage is provided for all of the following:

- (a) Mental health services for adults in a day treatment program offered by a provider certified by the Wisconsin department of health and family services;
- (b) Mental health services for children and adolescents in a day treatment program offered by a provider certified by the Wisconsin department of health and family services;
- (c) Services for persons with chronic mental illness provided through a community support program certified by the Wisconsin department of health and family services;
- (d) Residential treatment programs for alcohol or drug dependent persons or both certified by the Wisconsin department of health and social services;
- (e) Services for alcoholism and other drug problems provided in a day treatment program certified by the Wisconsin department of health and social services;
- (f) Intensive outpatient programs for the treatment of psychoactive substance use disorders provided in accordance with the patient placement criteria of the American Society of Addiction Medicine.

The maximum specified above do not include charges incurred for prescription drugs or diagnostic testing (procedures used to exclude the existence of conditions other than nervous or mental disorders or alcoholism or other drug abuse problems).

2. The **Age Limit for Children** subsection of the ELIGIBILITY, ENROLLMENT AND TERMINATION section is revised to add the following provision.

With respect to a Dependent child who is over 18 years of age and enrolled as a full-time student at a secondary or postsecondary educational institution, the following shall apply:

- (1) Any break in the school calendar shall not disqualify the Dependent child from coverage.
- (2) If the Dependent child takes a medical leave of absence, and the nature of the Dependent child’s Injury, Illness, or condition would render the Dependent child incapable of self-sustaining employment, such Dependent child will continue to be eligible for coverage, if the Dependent child is chiefly dependent on the Employee for support and maintenance.

- (3) (A) If the Dependent child takes a medical leave of absence from school, but the nature of the Dependent child's Injury, Illness, or condition does not meet the requirements of paragraph (2), the Dependent child's coverage will not terminate for a period not to exceed 12 months or until the date on which the coverage is scheduled to terminate pursuant to the terms and conditions of the Certificate, whichever comes first. The period of coverage under this paragraph shall commence on the first day of the medical leave of absence from the school or on the date the Physician determines the Illness prevented the Dependent child from attending school, whichever comes first. Any break in the school calendar will not disqualify the Dependent child from coverage under this paragraph.
- (B) Documentation or certification of the Medical Necessity for a leave of absence from school must be submitted to Us at least 30 days prior to the medical leave of absence from the school, if the medical reason for the absence and the absence are foreseeable, or 30 days after the start date of the medical leave of absence from school and will be considered prima facie evidence of entitlement to coverage under this paragraph.

3. The **Additional Services and Supplies** subsection of the Medical Benefit section of Your Certificate of Insurance is revised to add the following to **Diabetic Equipment**:

Coverage is also provided under this benefit for Covered Persons for insulin.

4. The following benefits are added to the **Additional Services and Supplies** section of Your Certificate. These benefits are in addition to any coverage otherwise payable under the Medical Benefit, or Outpatient Prescription Drug Benefit.

Childhood Immunization Coverage

Covered Services include charges incurred for childhood immunization of a covered Dependent child from birth through age 6. Coverage will consist of immunizations against diphtheria, pertussis, tetanus; polio, Haemophilus B (Hib); Hepatitis B; measles, mumps rubella; and varicella. Coverage is not subject to any Deductible, Copayment or Coinsurance requirements.

Lead Poisoning Screening for Children

Benefits are payable for blood lead tests for children under age 6. Benefits are payable in accordance with guidelines and criteria set forth by the Wisconsin departmental health and family services.

This coverage is in addition to any coverage provided under the plan for preventive care services.

Temporomandibular Disorders Coverage

Coverage is provided for diagnostic procedures and Medically Necessary surgical or nonsurgical treatment for the correction of temporomandibular disorders if all of the following apply:

1. The condition is caused by congenital, developmental or acquired deformity, disease or injury.
2. Under the accepted standards of the profession of the health care provider rendering the service, the procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition.
3. The purpose of the procedure or device is to control or eliminate infection, pain, disease, or dysfunction.

Coverage includes coverage for prescribed intraoral splint therapy devices but does not include coverage for cosmetic or elective orthodontic care, periodontic care or general dental care.

Coverage of temporomandibular disorders is subject to a maximum benefit of \$1,250 during any Calendar Year.

Hearing Aids, Cochlear Implants, and Related Treatment for Infants and Children

Coverage is provided for the cost of hearing aids and cochlear implants that are prescribed by a Physician, or by an audiologist licensed under subchapter II of chapter 459, Wisconsin statutes, in accordance with accepted professional medical or audiological standards, for a child covered under the plan who is under 18 years of age and who is certified as deaf or hearing impaired by a Physician or by an audiologist licensed under subchapter II of chapter 459, Wisconsin statutes.

Coverage includes the cost of treatment related to hearing aids and cochlear implants, including procedures for the implantation of cochlear devices, for a child specified above.

Coverage of the cost of hearing aids shall be limited to the cost of one hearing aid per ear per child every 3 years.

As used above:

“Cochlear implant” includes any implantable instrument or device that is designed to enhance hearing.

“Hearing aid” means any externally wearable instrument or device designed for or offered for the purpose of aiding or compensating for impaired human hearing and any parts, attachments, or accessories of such an instrument or device, except batteries and cords.

5. Coverage for Drugs for Treatment of HIV Infection

If Your Certificate includes an Outpatient Prescription Drug Benefit, coverage will be provided under the Outpatient Drug Benefit for any type of drugs that satisfy all of the following:

1. Is prescribed by the Covered Person’s Physician for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection.
2. Is approved by the federal food and drug administration for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection, including each Investigational new drug that is approved under 21 Code of Federal Regulations 312.34 to 312.36 for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection and that is in, or has completed, a phase 3 clinical investigation performed in accordance with 21 Code of Federal Regulations 312.20 to 312.33.
3. If the drug is an Investigational new drug described in subd. 2, is prescribed and administered in accordance with the treatment protocol approved for the investigational new drug under 21 Code of Federal Regulations 312.34 to 312.36.

The Copayment required for such drug will not exceed the Copayment required for other Prescription Drugs covered under the Outpatient Prescription Drug Benefit.

Coverage of Grandchildren

The subsection entitled **Who Is Eligible for Coverage**, under the ELIGIBILITY, EFFECTIVE DATES, AND TERMINATION section of Your Certificate is revised to include children of a Dependent child until such Dependent child attains age 18.

Contact us

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Customer Contact Center

Large Group:

1-800-676-6976

(for companies with 51 or
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Small Business Group:

1-800-361-3366

(for companies with 2-50 employees)

Individual & Family Plans:

1-800-839-2172

1-800-331-1777 (Spanish)

1-877-891-9053 (Mandarin)

1-877-891-9050 (Cantonese)

1-877-339-8596 (Korean)

1-877-891-9051 (Tagalog)

1-877-339-8621 (Vietnamese)

Telecommunications Device for the Hearing and Speech Impaired

1-800-995-0852

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